
Medicare

Provider Reimbursement Manual

Part 2 - Provider Cost Reporting Forms and Instructions - Chapter 38 - Form HCFA-1984-99

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal 2

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NEW/REVISED MATERIAL--EFFECTIVE DATE: Effective for cost reporting periods beginning on or after April 1, 1999.

This transmittal updates Chapter 38, Hospice Cost Report, Form HCFA 1984-99. This transmittal clarifies certain instructions in Transmittal #1.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

- C Proprietary - A proprietary hospice is owned and operated by an individual business corporation. The organization may be a sole proprietorship (individual), a partnership (including limited partnership and joint stock company) or a corporation. Indicate the type of operation.
- C Government - A government hospice is operated by a State, county, city or other local unit government.

3807.2 Part II--Enrollment days based on level of care.

Lines 8-11.--Enter on line 8 through 11 the enrollment days applicable to each type of care. Enrollment days are unduplicated days of care received by a hospice patient. A day is recorded for each day a hospice patient receives one of four types of care. Where a patient moves from one type of care to another, count only one day of care for that patient for the last type of care rendered. For line 10, an inpatient care day should be reported only where the hospice provides or arranges to provide the inpatient care.

For the purposes of the Medicare and Medicaid hospice programs, a patient electing hospice can receive only one of the following four types of care per day:

Continuous Home Care Day - A continuous home care day is a day on which the hospice patient is not in an inpatient facility. A day consists of a minimum of 8 hours and a maximum of 24 hours of predominantly nursing care. **Note: Convert continuous home care hours into days so that a true accountability can be made of days provided by the hospice.**

Routine Home Care Day - A routine home care day is a day on which the hospice patient is at home and not receiving continuous home care.

Inpatient Respite Care Day - An inpatient respite care day is a day on which the hospice patient receives care in an inpatient facility for respite care.

General Inpatient Care Day - A general inpatient care day is a day on which the hospice patient receives care in an inpatient facility for pain control or acute or chronic symptom management which cannot be managed in other settings.

Line 12.--Enter the total unduplicated days.

COLUMN DESCRIPTIONS

Column 1.--Enter only the unduplicated Medicare days applicable to the four types of care. Enter on line 12 the total unduplicated Medicare days.

Column 2.--Enter only the unduplicated Medicaid days applicable to the four types of care. Enter on line 12 the total unduplicated Medicaid days.

Column 3.--Enter only the unduplicated days applicable to the four types of care for all Medicare hospice patients residing in a skilled nursing facility. Enter on line 12 the total unduplicated days.

Column 4. --Enter only the unduplicated days applicable to the four types of care for all Medicaid hospice patients residing in a nursing facility. Enter on line 12 the total unduplicated days.

Column 5. --Enter in column 5 only the days applicable to the four types of care for all other non-Medicare or Medicaid hospice patients. Enter on line 12 the total unduplicated days.

Column 6.--Enter the total days for each type of care, (i.e., sum of columns 1, 2 and 5). The amount entered in column 6 line 12 should represent the total days provided by the hospice.

NOTE: Convert continuous home care hours into days so that column 6 line 12 reflects the actual total number of days provided by the hospice.

3807.3 Part III --Census data

Line 13.--Enter on line 13 the total number of patients receiving hospice care within the cost reporting period for the appropriate payer source.

The total under this line should equal the actual number of patients served during the cost reporting period for each program. Thus, if a patient's total stay overlapped two reporting periods, the stay should be counted once in each reporting period. The patient who initially elects the hospice benefit, is discharged or revokes the benefit, and then elects the benefit again within a reporting period is considered to be a new admission with a new election and should be counted twice.

A patient transferring from another hospice is considered to be a new admission and would be included in the count. If a patient entered a hospice under a payer source other than Medicare and then subsequently elects Medicare hospice benefit, count the patient once for each payer source.

The difference between line 13 and line 16 is that line 13 should equal the actual number of patients served during the reporting period for each program, whereas under line 16, patients are counted once, even if their stay overlaps more than one reporting period.

Line 14.--Enter the total title XVIII Unduplicated Continuous Care hours billable to Medicare. When computing the Unduplicated Continuous Care hours, count only one hour regardless of number of services or therapies provided simultaneously within that hour.

Line 15.--Enter the average length of stay for the cost reporting period. Include only the days for which a hospice election was in effect. The average length of stay for patients with a payer source other than Medicare and Medicaid is not limited to the number of days under a hospice election.

The statistics for a patient who had periods of stay with the hospice under more than one program is included in the respective columns. For example, patient A enters the hospice under the Medicare hospice benefit, stays 90 days, revokes the election for 70 days (and thus goes back into regular Medicare coverage), then reelects the Medicare hospice benefit for an additional 45 days, under a new benefit period as patient B, then dies. Medicare patient C was in the program on the first day of the year and died on January 29 for a total length of stay of 29 days. Patient D, with private insurance, received hospice care for 87 days. Patient E was admitted with private insurance for 27 days, until the private insurance ended, and Medicaid covered an additional 92 days. The average length of stay (LOS) (assuming these are the only patients the hospice served during the reporting period) is computed as follow:

Medicare Days (90 & 45 & 29)	164 Days
Patients (A, B & C)	
Medicare Patients	/3
Average LOS Medicare	54.67 Days
Medicaid Days Patient E (92)	92 Days
Medicaid Patients	/1
Average LOS Medicaid	92 Days

Other (Insurance) Days (87 & 27)	114
Other Patients (D & E)	/2
Average LOS (Other)	57 Days
All Patients (90+45+29+92+87+27)	370 Days
Total Number of patients	/6
Average LOS for all patients	61.67 Days

Enter the hospice's average length of stay, without regard to payer source, in column 6, line 15.

Line 16.--Enter the unduplicated census count of the hospice for all patients initially admitted and filing an election statement with the hospice within a reporting period for the appropriate payer source. Do not include the number of patients receiving care under subsequent election periods (See HCFA Pub. 21 §204). However, the patient who initially elects the hospice benefit, is discharged or revokes the benefits, and elects the benefit again within the reporting period is considered a new admission with each new election and should be counted twice.

The total under this line should equal the unduplicated number of patients served during the reporting period for each program. Thus, you would not include a patient if their stay was counted in a previous cost reporting period. If a patient enters a hospice source other than Medicare and subsequently becomes eligible for Medicare and elects the Medicare hospice benefit, then count that patient only once in the Medicare column, even though he/she may have had a period in another payer source prior to the Medicare election. A patient transferring from another hospice is considered to be a new admission and is included in the count.

Line 17.—If the hospice componentized (or fragmented) its administrative and general service costs, enter “1” for option 1 and “2” for option two. Do not respond if A&G services are not fragmented. (See §3820 for an explanation of the A&G componentization options.)

Line 18.—Are there any related organization or home office costs claimed? Enter “Y” for yes or “N” for no in column 1. If yes, enter the Chain Home Office's provider number in column 2. If yes, complete Worksheet A-8-1.

3810. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE EXPENSES

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for reclassification and adjustments to certain accounts. The cost centers on this worksheet are listed in a manner, which facilitates the transfer of the various cost center data to the cost finding worksheets (e.g., on Worksheets A, B, B-1, the line numbers are consistent, and the total line is set at 100). Not all of the cost centers listed apply to all providers using these forms.

If the cost elements of a cost center are separately maintained on your books, reconcile the costs for the accounting books and records with those on this worksheet. The reconciliation is subject to review by the intermediary.

Standard (i.e., preprinted) HCFA line numbers and cost center descriptions may not be changed. If you need to use additional or different cost center descriptions, add additional lines to the cost report. When an added cost center description bears a logical relationship to a standard line description, insert the added label immediately after the related standard line description.

Identify the added line as a numeric (only) subscript of the immediately preceding line, except when subscribing administrative and general (A&G) costs. That is, if two lines are added between lines 5 and 6, identify them as lines 5.01 and 5.02.

But if A&G costs (line 6) are subscripted, eliminate line 6 and begin subscripting with line 6.01. If additional lines are added for general service cost centers to Worksheet A, corresponding columns must be added to Worksheets B and B-1 as well as lines to Worksheet A-1, A-2, A-3, B, and B-1 for cost finding.

Cost center coding is a method for standardizing cost center labels used by health care providers on the Medicare cost reports. Form HCFA 1984-99 provides for preprinted cost center descriptions on Worksheet A. The preprinted cost center labels are automatically coded by HCFA approved cost reporting software.

These cost center descriptions are hereafter referred to as the standard cost centers. Nonstandard cost center descriptions are identified through analysis of frequently used labels.

Column 1--Obtain salaries to be reported from Worksheet A-1, col. 9, line 3-100.

Column 2--Obtain employee benefits to be reported from Worksheet A-2 col. 9 lines 3-100.

Column 3--If the transportation costs, i.e., owning or renting vehicles, public transportation expenses, or payments to employees for driving their private vehicles can be directly identified to a particular cost center, enter those costs in the appropriate cost center. If these costs are not identified to a particular cost center enter them on line 6.

Column 4--Obtain the contracted services to be reported from Worksheet A-3, col. 9 lines 3-100.

Column 5--Enter in the applicable lines in column 5 all costs which have not been reported in columns 1 through 4.

Column 6--Add the amounts in columns 1 through 5 for each cost center and enter the total in column 6.

Column 7--Enter any reclassifications among cost center expenses in column 6 which are needed to effect proper cost allocation.

Worksheet A-6 reflects the reclassifications affecting the cost center expenses. This worksheet need not be completed by all providers, but is completed only to the extent reclassifications are needed and appropriate in the particular circumstances. Show reductions to expenses in parentheses ().

The net total of the entries in column 7 must equal zero on line 100.

Column 8--Adjust the amounts entered in column 6 by the amounts in column 7 (increases and decreases) and extend the net balances to column 8. The total of column 8 must equal the total of column 6 on line 100.

Column 9--Enter on the appropriate lines in column 9, the amounts from Worksheet A-8. The total on Worksheet A, column 9, line 100 must equal Worksheet A-8, column 2, line 11.

Column 10--Adjust the amounts in column 8 by the amounts in column 9, (increases or decreases) and extend the net balances to column 10.

LINE DESCRIPTIONS

Lines 1 and 2 - Capital Related Cost - Buildings and Fixtures and Capital Related Cost -Movable Equipment.--These cost centers should include depreciation, leases and rentals for the use of the facilities and/or equipment, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care and taxes on land or depreciable assets used for patient care. Do not include in these cost centers the following costs: costs incurred for the repair or maintenance of equipment or facilities; amounts included in the rentals or lease or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care.

Line 3 - Plant Operation and Maintenance.--This cost center contains the direct expenses incurred in the operation and maintenance of the plant and equipment, maintaining general cleanliness and sanitation of plant, and protecting the employees, visitors, and agency property.

Plant Operation and Maintenance include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes the cost of maintenance and repair of building, parking facilities and equipment, painting, elevator maintenance, performance of minor renovation of buildings, and equipment.

3813. WORKSHEET A-3 – COMPENSATION ANALYSIS - CONTRACTED SERVICES/PURCHASED SERVICES

The hospice may contract with another entity for the provision of non-core hospice services. However, nursing care, medical social services and counseling are core hospice services and must routinely be provided directly by hospice employees. Supplemental services may be contracted in order to meet unusual staffing needs that cannot be anticipated and that occur so infrequently it would not be practical to hire additional staff to fill these needs. You may also contract to obtain physician specialty services. If contracting is used for any services, maintain professional, financial and administrative responsibility for the services and assure that all staff meet the regulatory qualification requirements.

Enter on this worksheet all contracted and/or purchased services for the hospice. Enter the contracted/purchased cost on the appropriate cost center line within the column heading which best describes the type of services purchased. Costs associated with contracting for general inpatient or respite care would be recorded on this worksheet. For example, where physical therapy services are purchased, enter the contract cost of the therapist in column 6, line 17. If a contracted/purchased service covers more than one cost center, then the amount applicable to each cost center is included on each affected cost center line. Add the amounts of each cost center, columns 1 through 8, and enter the total in column 9. Transfer these totals to Worksheet A, column 4, corresponding lines. To facilitate transferring amounts from Worksheet A-3 to Worksheet A, the same cost centers with corresponding line numbers are listed on both worksheets.

3816. WORKSHEET A-6 - RECLASSIFICATIONS AND ADJUSTMENTS TO EXPENSES

This worksheet provides for the reclassification of certain costs to effect proper cost allocation under cost finding. For each reclassification adjustment, assign an alpha character, e.g., A, B, C. **DO NOT USE NUMERIC DESIGNATIONS.**

Submit with the cost report copies of any work papers used to compute the reclassifications effected on this worksheet.

Identify any reclassifications made as salary and other costs in the appropriate column. However, when transferring to Worksheet A, transfer the sum of the two columns.

Examples of reclassifications that may be needed are:

- o Reclassification of related organization rent expenses included in the A & G cost center which are applicable to lines 1 through 4 of Worksheet A. See instructions for Worksheet A-8-1 for treatment of rental expenses for related organizations.
- o Reclassification of employee benefits expenses (e.g., personnel department, employee health service, hospitalization insurance, workers compensation, employee group insurance, social security taxes, unemployment taxes, annuity premiums, past service benefits, and pensions) included in the A & G cost center.

3817. WORKSHEET A-7 - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

Columns 1 and 6.--Enter the balance recorded in your books at the beginning of your cost reporting period (column 1) and at the end of your cost reporting period (column 6).

Columns 2 through 4.--Enter the cost capital assets acquired by purchase in column 2. In column 3, enter the fair market value, at date acquired, for donated assets. Enter the sum of column 2 and 3 in column 4.

Column 5.--Enter the cost or other basis of all capital assets sold, traded or transferred, retired, or disposed of in any manner during your cost reporting period.

Column 6 equals the sum of columns 1 and 4 minus column 5.

3818. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

In accordance with 42 CFR 413.9(c)(3), where your operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (i.e., those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts are not allowable.

This worksheet provides for the adjustment in support of those expenses listed on Worksheet A, column 9. These adjustments, which are required under Medicare principles of reimbursement, are made on the basis of "cost" or "amount received" (revenue) only if the cost (including direct cost and all applicable overhead) cannot be determined. If the total direct and indirect cost can be determined, enter the "cost." **Submit with the cost report a copy of any work papers used to compute a cost adjustment. Once an adjustment to an expense is made on the basis of "cost", you can not determine the required adjustment to the expense on the basis of "revenue" in future cost reporting periods. The following symbols are entered in column 2 to indicate the basis for adjustment: "A" for cost; "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs, or result in costs incurred for reasons other than patient care and thus require adjustments.**

Types of adjustments entered on this worksheet are (1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, or fees; (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process.

Where an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on Worksheet A-8.

Line 1.--Enter the investment income to be applied against interest expense. (See HCFA Pub.15-I, §202.2 for explanation.)

Line 2.--For patient telephones, make an adjustment on this line or establish a nonreimbursable cost center. When line 2 is used, the adjustment must be based on cost. Revenue cannot be used.

Line 3.--Enter allowable home office costs and/or related organizations which have been allocated to the hospice and which are not already included in the provider cost report. Additional lines are used to the extent that various hospice cost centers are affected. (See HCFA Pub. 15-I, §§2150 - 2153.)

Line 4.--Enter the amount received from the sale of meals to employees and guests. This income is used to offset the dietary expense.

Line 5.--Enter the cash received from imposition of interest, finance, or penalty charges on overdue receivables. This income must be used to offset the allowable administration and general costs. (See HCFA Pub. 15-I, §2110.2.)

Line 6.--Enter all bad debts both Medicare and non-Medicare which are included on the trial balance.

Line 7.--Include items a patient purchases from the facility, the cost of which is included in any of the cost centers on Worksheet A such as laundry and linen service.

Line 8.--Enter amounts not previously covered on lines 1 through 7. **If there are a number of adjustments, attach a schedule reflecting the miscellaneous adjustment and enter the total on line 8.**

Lines 9 -10.--Where depreciation expense computed in accordance with the Medicare principles of reimbursement differs from depreciation expenses per the provider's books, enter the difference on line 9, and/or 10. (See HCFA Pub. 15-I, Chapter 1.)

Line 11.- Enter the sum of lines 1 through 10 and transfer all amounts entered on lines 1-10 to the appropriate lines on Worksheet A, column 9.

3818.1 WORKSHEET A-8-1 – Statement of Costs of Services from Related Organizations and Home Office Costs

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the hospital by organizations related to you or costs associated with the home office.

Part A.--Cost applicable to home office and related organization costs, services, facilities, and supplies furnished to you by organizations related to you by common ownership or control are includable in your allowable cost at the cost to the related organizations. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

Part B.--Use this part to show your relationship to organizations identified in Part A. Show the requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in HCFA Pub. 15-I, chapter 10 in columns 1 through 6, as appropriate.

Complete only those columns, which are pertinent to the type of relationship which, exists.

Column 1.--Enter the appropriate symbol which describes your relationship to the related organization.

Column 2.--If the symbol A, D, E, F, or G is entered in column 1, enter the name of the related individual in column 2.

Column 3.--If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in you, enter the percent of ownership as a ratio.

Column 4.--Enter the name of the related corporation, partnership, or other organization.

Column 5.--If you or the individual indicated in column 2 has a financial interest in the related organizations, enter the percent of ownership in such organization as a ratio.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service).

**3820. WORKSHEET B - COST ALLOCATION - GENERAL SERVICE COSTS AND
WORKSHEET B-1 - COST ALLOCATION - STATISTICAL BASIS**

Worksheet B provides for the allocation of the expenses of each general service cost center to those cost centers which receive the services. The cost centers serviced by the general service cost centers include all cost centers within the provider organization, i.e., other general service cost centers, reimbursable cost centers, nonreimbursable cost centers. Obtain the total direct expenses from Worksheet A, column 10. To facilitate transferring amounts from Worksheet A to Worksheet B, the same cost centers with corresponding line numbers (lines 1 through 100) are listed on both worksheets.

Worksheet B-1 provides for the proration of the statistical data needed to equitably allocate the expenses of the general service cost centers on Worksheet B.

To facilitate the allocation process, the general format of Worksheets B and B-1 are identical. The column and line numbers for each general service cost center are identical on the two worksheets. In addition, the line numbers for each general, reimbursable, nonreimbursable, and special purpose cost centers are identical on the two worksheets. The cost centers and line numbers are also consistent with Worksheets A, A-1, A-2, and A-3. If the provider has subscripted any lines on these A worksheets, the provider must subscript the same lines on the B worksheets.

NOTE: General service columns 1 through 5 and subscripts thereof must be consistent on Worksheets B and B-1.

The statistical bases shown at the top of each column on Worksheet B-1 are the recommended bases of allocation of the cost centers indicated. If a different basis of allocation is used, the provider must indicate the basis of allocation actually used at the top of the column.

Most cost centers are allocated on different statistical bases. However, for those cost centers where the basis is the same (e.g., square feet), the total statistical base over which the costs are to be allocated will differ because of the prior elimination of cost centers that have been closed.

Close the general service cost centers in accordance with 42 CFR 413.24(d)(1) which states, in part, that A the cost of non revenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. This is clarified in HCFA Pub. 15-I, §2306.1, which further clarifies the order of allocation for stepdown purposes. Consequently, first close those cost centers that render the most services to and receive the least services from other cost centers. The cost centers are listed in this sequence from left to right on the worksheet. However, the circumstances of an agency may be such that a more accurate result is obtained by allocating to certain cost centers in a sequence different from that followed on these worksheets.

NOTE: A change in order of allocation and/or allocation statistics is appropriate for the current fiscal year cost if received by the intermediary, in writing, within 90 days prior to the end of that fiscal year. The intermediary has 60 days to make a decision or the change is automatically accepted. The change must be shown to more accurately allocate the overhead or, if the allocation is accurate, it should be changed due to simplification of maintaining the statistics. If a change in statistics is made, the provider must maintain both sets of statistics until an approval is made.

In addition, report on line 6 the administrative and general costs reported on Worksheet B, column 6, line 6 since these costs are not included on Worksheet B-1, column 6 as an accumulated cost statistic.

For fragmented or componentized A&G cost centers, the accumulated cost center line number must match the reconciliation column number. Include in the column number the alpha character "A", i.e., if the accumulated cost center for A&G is line 6 (A&G), the reconciliation column designation must be 6A.

If A& G is not fragmented or componentized, the reconciliation column designation must be 6A.

Worksheet B-1, Column 6--The administrative and general expenses are allocated on the basis of accumulated costs. Therefore, the amount entered on Worksheet B-1, column 6, line 6, is the difference between the amounts entered on Worksheet B, column 5A and Worksheet B-1, column 6A. A negative cost center balance in the statistics for allocating administrative and general expenses causes an improper distribution of this overhead cost center. Exclude negative balances from the allocation statistics.

Hospices may establish multiple A&G cost centers (referred to as componentized or fragmented) by using one of two methods. The rationale for allocating the shared A&G service cost center first is that shared A&G cost centers service all other cost centers, while 100 percent of the hospice A&G reimbursable and 100 percent of hospice A&G nonreimbursable only service their respective cost centers. That is consistent with 42 CFR 413.24(d)(1), which states, in part, that the cost of nonrevenue-producing cost centers serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first.

Under the first method (also referred to as option 1), the hospice must classify all A&G costs as either A&G shared costs, A&G reimbursable costs, or A&G nonreimbursable costs. That is, 100 percent of the componentized A&G costs relate exclusively to either the hospice reimbursable or the hospice nonreimbursable cost centers. The remaining costs are classified as A&G shared costs. The componentized A&G costs are allocated through cost finding to their respective cost centers in aggregate.

First, allocate A&G shared costs to all applicable cost centers, including to the A&G reimbursable and A&G nonreimbursable cost centers on the basis of accumulated costs. Then allocate hospice A&G reimbursable costs to all applicable Hospice reimbursable cost centers (not including special purpose cost centers) on the basis of accumulated costs, and allocate hospice A&G nonreimbursable costs to all applicable hospice nonreimbursable cost centers on the basis of accumulated costs. Only A&G shared costs are allocated to the special purpose cost centers.

The following three A&G cost center categories will be created: (1) A&G shared costs, (2) 100 percent hospice reimbursable costs, and (3) 100 percent Hospice nonreimbursable costs, in this order only. Do not allocate A&G reimbursable costs to the A&G nonreimbursable cost center. Calculate the accumulated cost statistics as follows:

<u>A&G Cost Center</u>	<u>Sum of Worksheet B</u>	<u>Transfer to Worksheet B-1</u>
A&G Shared Costs	Col. 0-5, lines 6.02-100	Col. 6.01, lines 6.02-100
A&G Reimb. Costs	Col. 0-6.01, lines 7-40	Col. 6.02, lines 7-40
A&G Nonreimb. Costs	Col. 0-6.01, lines 50-100	Col. 6.03, lines 50-100

Under the second method (also referred to as option 2), unique A&G cost centers may be created (see HCFA Pub. 15-I, §2313.1) to further refine the allocation process. The statistical basis upon which to allocate fragmented A&G costs must represent, as accurately as possible, the consumption or usage of A&G services by the benefiting cost centers.

Hospices wishing to use an alternative allocation method (i.e., a change in allocation basis or the sequence of cost center allocation) must do so in accordance with HCFA Pub. 15-I, §2313. The fragmentation of A&G costs constitutes a direct assignment of A&G costs and as such must follow the policy established under §2307 of HCFA Pub. 15-I.

3830. WORKSHEET D - CALCULATION OF PER DIEM COST

Worksheet D calculates the average cost per days in providing care for a hospice patient. It is only an average and should not be misconstrued as the absolute.

Line 1.--Total cost from Worksheet B, line 100, column 7, less line 53, column 7. This line reflects the true cost without any non-hospice-related cost.

Line 2.--Total unduplicated days from Worksheet S-1, line 12, col. 6.

Line 3.--Average cost per day. Divide the total cost from line 1 by the total number of days from line 2.

Line 4.--Unduplicated Medicare days from Worksheet S-1, line 12, column 1.

Line 5.--Average Medicare cost. Multiply the average cost from line 3 by the number of unduplicated Medicare days on line 4 to arrive at the average Medicare cost.

Line 6.---Unduplicated Medicaid days from Worksheet S-1, line 12, column 2.

Line 7.---Average Medicaid cost. Multiply the average cost from line 3 by the number of unduplicated Medicaid days on line 6 to arrive at the average Medicaid cost.

Line 8.--Unduplicated SNF days from Worksheet S-1, line 12, column 3.

Line 9.--Average SNF cost. Multiply the average cost from line 3 by the number of unduplicated SNF days on line 8 to arrive at the average SNF cost.

Line 10.--Unduplicated NF days from Worksheet S-1, line 12, column 4.

Line 11.--Average NF cost. Multiply the average cost from line 3 by the number of unduplicated NF days on line 10 to arrive at the average NF cost.

Line 12.---Unduplicated Other days from Worksheet S-1, line 12, column 5.

Line 13.--Average Other cost. Multiply the average cost from line 3 by the number of unduplicated Other days on line 12 to arrive at the average Other cost.

Line 14.--Total cost add lines 5, col. 1 plus line 7 col. 2 and line 13, col. 3. Line 14 must equal line 1 col. 4. Line 9, col. 1 average SNF cost is already accounted for in the total Medicare cost for Title XVIII. Similarly line 11, col. 2, is already accounted for on line 7, col. 2 for Medicaid cost for Title XIX.

Line 15.---Total days add lines 4, col. 1 plus line 6 col. 2 and line 12, col. 3. Line 15 must equal line 2 col. 4. Line 8, col. 1 unduplicated SNF days is already accounted for in the total Medicare cost for Title XVIII. Similarly line 10, col. 2, is already accounted for on line 6, col. 2 for Medicaid cost for Title XIX.

3850. WORKSHEET G - BALANCE SHEET

3850.1 Worksheet G-1 - Statement of Changes in Fund Balances.3850.2 Worksheet G-2 - Statement of Patient Revenues and Net Income.

Part I.--General Inpatient and Home Care Service Locations—Lines 1 through 4 reflects patients revenues from the various locations where a patient may reside. Attach schedule to reflect the following: hospice inpatient revenue and any other revenues received from other sources such as donations or contributions.

Part II.--Operating Expenses.—Reflects the operating expenses for the cost reporting period.

Prepare these worksheets from your accounting books and records. Additional Worksheets may be submitted, if necessary.

All providers maintaining fund-type accounting records complete worksheets G and G-1. Nonproprietary providers who do not maintain fund-type accounting records complete general fund columns only.

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 NO.:	PERIOD:	WORKSHEET S
			FROM TO	
Intermediary use only	<input type="checkbox"/> Audited <input type="checkbox"/> Desk Reviewed	Date Received: _____		<input type="checkbox"/> Initial <input type="checkbox"/> Reopening <input type="checkbox"/> Final
		Intermediary No. _____		

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 OR PRODUCED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above 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 Names(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement 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.

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

Phone Number: Area Code

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0758. The time required to complete this information collection is estimated to average 176 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: HCFA, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503

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

1.	Name:	Address:	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.	
7.	Type of Control (see instructions)			7.	

PART II

Enrollment Days	Title XVIII	Title XIX	Title XVIII	Title XIX	Other Unduplicated	Total Unduplicated Days	
	Unduplicated Medicare Days	Unduplicated Medicaid Days	Unduplicated Skilled Nursing Facility Days	Unduplicated Nursing Facility Days			
	1	2	3	4			
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	Title XIX	Other	Total	
		Title XVIII	Title XIX	Title XVIII	Title XIX			
		1	2	3	4			
13.	Number of Patients Receiving Hospice Care							13.
14.	Total Number of Unduplicated Continuous 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 HCFA Pub. 15-I, chapter 10? 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.)	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 & 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 Fixt.										1
2	0200	Capital Related Costs-Movable Equip.										2
3	0300	Plant Operation and Maintenance										3
4	0400	Transportation - Staff										4
5	0500	Volunteer Service Coordination										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
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
25		Other										25
OTHER HOSPICE SERVICE COSTS												
30	3000	Drugs, Biological and Infusion Therapy										30
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

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	
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	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										
10 Inpatient - General Care										10
11 Inpatient - Respite Care										11
VISITING SERVICES										
15 Physician Services										15
16 Nursing Care										16
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
25 Other										25
OTHER HOSPICE SERVICE COSTS										
30 Drugs, Biological and Infusion Therapy										30
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

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

COMPENSATION ANALYSIS SALARIES AND WAGES			PROVIDER NO:		PERIOD:				WORKSHEET A-1	
					FROM _____					
					TO _____					
COST CENTER DESCRIPTIONS (omit cents)	ADMINIS TRATOR	DIRECTOR	SOCIAL SERVICES	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
	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	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										
10	Inpatient - General Care									10
11	Inpatient - Respite Care									11
VISITING SERVICES										
15	Physician Services									15
16	Nursing Care									16
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
25	Other									25
OTHER HOSPICE SERVICE COSTS										
30	Drugs Biological and Infusion Therapy									30
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

(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	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
	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	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										
10	Inpatient - General Care									10
11	Inpatient - Respite Care									11
VISITING SERVICES										
15	Physician Services									15
16	Nursing Care									16
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
25	Other									25
OTHER HOSPICE SERVICE COSTS										
30	Drugs, Biological and Infusion Therapy									30
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

(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	SUPER- VISORS	NURSES	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	1	2	3	4	5	6	7	8	9	
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

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
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 & Fixture	1	9
10	Depreciation--movable equipment			Movable Equipmen	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 HCFA 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
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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 Wkst. 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 Health Care Financing Administration 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.

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office			
				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 _____

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

STATEMENT OF PATIENT REVENUES AND NET INCOME	PROVIDER NO:	PERIOD: FROM TO	WORKSHEET G - 2 PARTS I & II
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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