04-24	ł	FORM CM	S-1728-20	28-20 47				
paymer	nts made since the	beginning of the cost reporting period being deemed overpayments (42			FORM APPROVED OMB NO. 0938-0022 EXPIRES: 01/31/2027			
			HHA CCN:	PERIOD: FROM: TO:	WORKSHEET S PARTS I, II & III			
PART	I - COST REPOR	T STATUS						
		1. [ ] Electronically prepared cost report.						
Contrac	his report is required by ayments made since the IOME HEALTH AGEN CERTIFICATION AND ART I - COST REPOR rovider use only Contractor use only Contractor use only Contractor use only CIVIL AND ADI THIS REPORT W ILLEGAL, CRIM CERTIFICATION I HEREBY CER' cost report and th the cost report and the cost report and the the cos	(2) Settled without audit 8. [ ] Initial Repo	ort for this HHA CCN	12. [ ] If line 5, col	umn 1 is 4: Enter the number of			
		(0) 1 110000						
	I HEREBY CER cost report and th the cost reporting are true, correct, that I am familiar	TIFY that I have read the above certification statement and that I have ex as Balance Sheet and Statement of Revenue and Expenses prepared by geriod beginning and ending and the complete and prepared from the books and records of the provider in acc with the laws and regulations regarding the provision of health care serve	xamined the accompanyir nat to the best of my know cordance with applicable	{Provider Name(s) as vledge and belief, this repo- instructions, except as not	nd Number(s)} for ort and statement ed. I further certify			
	SIGNAT	JRE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX					
1		1	2	I have read and agree certification statement my electronic signa	e with the above 1 ent. I certify that I intend ture on this certification			
2	Printed Name				2			
					3			
4	Signature date				4			
PART	III - SETTLEMEI	NT SUMMARY						
	port is required by Jaw (42 USC 1352; 42 CTR 415.20(b)). Failure to report can result in all interim       FORM APPROVED         is made since the beginning of the cost reporting period being deemed overpayments (42 USC 135g).       OMB NO.098.0022         EFRALTH AGENCY COST REPORT       HHA CCN:       PERIOD.         FEALTH AGENCY COST REPORT       HHA CCN:       PERIOD.         FEALTH AGENCY COST REPORT STATUS       DATE:       TIME:         1. [] Electronically prepared cost report.       DATE:       TIME:         2. [] Manually prepared cost report enter the number of times the provider reabmintid this cost report.       [] <i>Underlane</i> Ublization.       TIME:         2. [] Cost Report Status       6. Date Received:       []       10. NPR Dutie:       []         (1) Assaming with addit a.       8. [] ] Initial Report for this HHA CCN       []       Unarcator Voic:       []       []       [] Cost Report Status       6. Date Received:       [] </td <td></td>							
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1	HOME HEALT	HAGENCY	EXPIRES: 01/31/2027         FROM:		1			
The ab	This report is required by two (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED Dyported and since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). ONB 80.022 EXPIRES: 0).51/2027 EVERSE: 0).51/2027 EV	•						

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 0938-0022. The time required to complete this information collection is estimated 195 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: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection unmber listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns reparding where to submit your documents, please contact 1-800-MEDICARE.

IDENTIFICATION DATA     IHA CCN:     PERIOD: NORSHEET 5.2, PART 1       HOME HEALTH AGENCY COMPLEX ADDRESS     1     0     0       I     1     2     0     1       I     Address 1     2     1     0     1       I     Address 2     0     0     1     1       I     1     2     3     1     0     1       I     1     2     3     1     0     1     2       I     Address 2     1     2     3     1     2     2       IOME IEALTH AGENCY COMPONENT IDENTIFICATION     COMPONENT NAME     2     3     3       IOME Health Agency     1     2     3     3       IOME HEALTH AGENCY COMPONENT IDENTIFICATION     1     2     3     3       IOME HEALTH AGENCY COMPONENT NAME     PROVIDER CCN     DATE CERTIFIED     4       I     2     3     3     3     3     3       IOME HEALTH AGENCY COMPONENT IDENTIFICATION     1     2     3     3       IOME HE	4795 (Cont.)			F	ORM CMS-1728	3-20				04-24
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6       Type of control (see instructions)       6       6       7         7       Does the 1HIA qualify as a nominal charge provider (see 42 CFR 409.3)?       6       7         8       Does the 1HIA contract with outside suppliers for occurational therapy services?       8       8         9       Does the 1HA contract with outside suppliers for occurational therapy services?       9       8       8         10       Does the 1HA contract with outside suppliers for occurational therapy services?       9       10         11       Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs as as defined in CMS Pake 15-1, chapter 10? If yes, complete Worksheet A-8-1.       11         MALPRACTICE INSURANCE INFORMATION         12       Is this HIA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         13       If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy.       PREMIUMS       PAID LOSSES       SELF-INSURANCE         14       List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.       14       14       14         15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       15         HOME OFFICE/CHAIN ORGANIZATION		1	2							
7       Does the HHA qualify as a nominal charge provider (see 42 CFR 409.3)?       7         8       Does the HHA contract with outside suppliers for physical therapy services?       8         9       Does the HHA contract with outside suppliers for physical therapy services?       8         10       Does the HHA contract with outside suppliers for speech therapy services?       10         11       Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs       10         11       as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.       11         MALPRACTICE INSURANCE INFORMATION         12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         13       If line 12 is yes, is the malpractice insurance? Enter "Y" for yes or "N" for no.       12         13       If line 12 is yes, is the malpractice insurance or calians-made or "2" for occurrence policy.       12         14       List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.       14         15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       14         16       HO/CO cost allocation       NUMBER OF       CONTRACTOR       STREET       CITY       ST	5 Cost Reporting Period:									5
7       Does the HHA qualify as a nominal charge provider (see 42 CFR 409.3)?       7         8       Does the HHA contract with outside suppliers for physical therapy services?       8         9       Does the HHA contract with outside suppliers for physical therapy services?       8         10       Does the HHA contract with outside suppliers for speech therapy services?       10         11       Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs       10         11       as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.       11         MALPRACTICE INSURANCE INFORMATION         12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         13       If line 12 is yes, is the malpractice insurance? Enter "Y" for yes or "N" for no.       12         13       If line 12 is yes, is the malpractice insurance or calians-made or "2" for occurrence policy.       12         14       List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.       14         15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       14         16       HO/CO cost allocation       NUMBER OF       CONTRACTOR       STREET       CITY       ST									T	
8         Does the HHA contract with outside suppliers for physical therapy services?         6         8           9         Does the HHA contract with outside suppliers for occurational therapy services?         10         10         10         11         Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.         11         11           MALPRACTICE INSURANCE INFORMATION         7         7         12         15 HHA Legalt required to carry malpractice insurance? Enter "Y" for yes or "N" for no.         12         12         15 HHA Legalt required to carry malpractice insurance? Enter "Y" for yes or "N" for no.         12         12         15 Hin 12 is yes, is the malpractice insurance? Enter "Y" for yes or "N" for no.         12         12         14 HA Legalt required to carry malpractice insurance? Enter "Y" for yes or "N" for no.         12         12         15 Hin 12 is yes, is the malpractice insurance a claims-made or cocurrence policy? Enter "1" for claims-made or "2" for occurrence policy.         12         12         14 List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.         12         13         14         12         14         14         15         14         15         14         14         15         14         15         14         15         15         15         15         15			- 42 CED 400 2)9							-
9       Does the HHA contract with outside suppliers for speech therapy services?       9         10       Does the HHA contract with outside suppliers for speech therapy services?       10         11       Are there any costs included in Worksheet A Ha resulted from transactions with related organizations or HO/COs as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.       10         MALPRACTICE INSURANCE INFORMATION         The 12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         11       Are the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.       12         14       List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.       14         14       List amounts of malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       16         16       HO/CO cost allocation       16         16       HO/CO cost allocation       16         16       NAME       CCN       CONTRACTOR       STREET       CITY       STATE       ZIP CODE										
10         Does the HHA contract with outside suppliers for speech therapy services?         10           11         Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs as defined in CMS Pub. 15-1, chapter 10? If yes, contract with speech A-8-1.         11           MALPRACTICE INSURANCE INFORMATION           12         Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.         12           13         If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "I" for claims-made or "2" for occurrence policy.         13           14         List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.         14           15         Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.         14           16         HO/CO cost allocation         NAME         CONTRACTOR         STREET         I16           16         HO/CO cost allocation         1         2         3         4         5         6         7										
11       Are there any costs included in Worksheet A that resulted from transactions with related organizations or HO/COs as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.       11         MAIPRACTICE INSURANCE INFORMATION         12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         12       Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.       12         13         If insurance a claims-made or occurrence policy? Enter "I" for claims-made or "2" for occurrence policy.       13         14         14       List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.       14       2       3         14         15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       14       15         14         NECEIVE       NUMBER OF         ALLOCATION       ORGANIZATIONS         14       List amounts of malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       14         16       NO/CO cost allocat										-
as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.       Image: Complete Worksheet A-8-1.       Image				lated organizations or	r HO/COs					
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Image: constraint of malpractice premiums, paid losses, and self-insurance in the applicable columns.       Image: constraint of malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       Image: constraint of the applicable columns.       Image: constrain	13 If line 12 is yes, is the main	practice insurance a claims-r	nade or occurrence policy?	Enter "1" for claims-n	nade or "2" for occurren	ce policy.	DDEMIIIMS	PAID LOSSES	SELE INSUDANCE	13
15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       15         HOME OFFICE/CHAIN ORGANIZATION INFORMATION         RECEIVE NUMBER OF ALLOCATION ORGANIZATIONS         1       2         16       HO/CO cost allocation       CONTRACTOR       STREET       16         Image: Street							1	2	3	-
15       Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.       15         HOME OFFICE/CHAIN ORGANIZATION INFORMATION         RECEIVE NUMBER OF ALLOCATION ORGANIZATIONS         1       2         16       HO/CO cost allocation       CONTRACTOR       STREET       16         Image: Street	14 List amounts of malpractice	e premiums, paid losses, and	self-insurance in the application	able columns.			1	2	5	14
HOME OFFICE/CHAIN ORGANIZATION INFORMATION       Receive     NUMBER OF       ALLOCATION     ORGANIZATIONS       1     2       16     HO/CO cost allocation       NAME     CCN     NUMBER       1     2       16     HO/CO cost allocation       11     2       12     1       13     2       14     2       15     1       16     1       17     2       18     3       19     4       10     2       10     1       10     2       10     1       10 <td></td> <td></td> <td></td> <td></td> <td>porting schedule listing</td> <td>cost centers and amou</td> <td>ints contained therein.</td> <td></td> <td></td> <td></td>					porting schedule listing	cost centers and amou	ints contained therein.			
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NAME         CCN         NUMBER         ADDRESS         CITY         STATE         ZIP CODE           1         2         3         4         5         6         7	16 HO/CO cost allocation		<u> </u>		CONTRACTOR	STREET				16
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	17 HO/CO Information			-						17

# FORM CMS-1728-20

9-20	FURM CM3	5-1/28-20		4/95	(Cont.)
EIMBURSEMENT DATA		HHA CCN:	PERIOD:	WORKSHEET S-2,	
EINIBORGEMENT DATA		inni ceiu			
			FROM:	PART II	
			— TO:		
OVIDER ORGANIZATION AND	OPERATION				
		Y/N	DATE	V/I	
		1	2	3	_
		1	2	3	1
	ship prior to the beginning of this cost reporting				1
period? (see instructions) Ent	er "Y" for yes or "N" for no in column 1.				
	ange in column 2. (see instructions)				
					_
2 Has the HHA terminated parts	cipation in the Medicare program? Enter "Y" for				2
yes or "N" for no in column 1	If yes, enter in column 2 the termination				
date and enter in column 3 "	V" for voluntary or "I" for involuntary.				
	ess transactions, including management contracts,				
	g., chain home offices, drug or medical supply				
supply companies) that are rel	ated to the provider or its officers, medical staff,				
management personnel or me	mbers of the board of directors through				
<b>e</b> 1	6				
	and other similar relationships? Enter "Y"				
for yes or "N" for no in colum	n 1. (see instructions)				
ANCIAL DATA AND REPORTS					
		Y/N	A / C / R	DATE	
		1	2	3	
4 Column 1: Were the financial	statements prepared by a certified public				
accountant? Enter "Y" for yes					
Column 2: If yes, enter: "A"	for audited, "C" for compiled, or "R" for reviewed.				
Submit complete copy of finan	ncial statements or enter date available in column 3.				
	uses and total revenues different from those on				
	Enter "Y" for yes or "N" for no in column 1. If				
yes, submit reconciliation.					
D DEBT					
				Y/N	
6 Is the HHA or HHA-based en	tities seeking reimbursement for bad debts? If yes,	see instructions.			(
	bad debt collection policy change during this cost re		and mait a surv		
			donin copy.		
8 If line 6 is yes, were patient co	binsurance amounts waived? If yes, see instructions	•			
&R REPORT DATA					-
			Y/N	DATE	_
			1	2	
9 Was the cost report prepared	using the PS&R report only? Enter "Y" for yes or "	N" for no in column 1.			
	baid-through date of the PS&R report used to prepar				
		e the cost			
report. (mm/dd/yyyy) (see in				_	
10 Was the cost report prepared	using the PS&R report for totals and the provider's r	ecords for allocation?			1
Enter "Y" for yes or "N" for t	no in column 1. If yes, enter in column 2 the paid-th	rough date of the			
PS&R report. (mm/dd/yyyy)		iougn dute of the			
					-
	ustments made to PS&R report data for additional c				1
billed but are not included on	the PS&R report used to file the cost report? Enter	"Y" for yes or			
"N" for no. If yes, see instruc	tions.				
	ustments made to PS&R report data for corrections	of other PS&P report			1
12 IT fine 9 of 10 is yes, were auj	usanents made to i Seek report data for corrections	or other i beek report			
	es or "N" for no. If yes, see instructions.				
13 If line 9 or 10 is yes, were adj	ustments made to PS&R Report data for Other? If	yes, describe			1
the other adjustments:					
	only using the HHA's records? Enter "Y" for yes or	"N" for no If yes	1		1
see instructions.	and and an infinite records. Enter 1 for yes of	1. 101 110. 11 yes,			
see instructions.					
T DEDODT DDED ( DED. CONT.	OT DIFORMATION				
ST REPORT PREPARER CONTA					-
		LAST NAME		TITLE	
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15 Preparer					1
16 Employer Name					1
1	TELEPHONE NUMBER		EMAIL ADDRESS		
	TELEPHONE NUMBER		EMAIL ADDRESS		_
	TELEPHONE NUMBER		EMAIL ADDRESS 2		_
17 Contact	TELEPHONE NUMBER				1

ATISTICAL DATA			HHA CCN:		PERIOD: FROM: TO:		WORKSHEET S-3 PARTS I, II, & III	
RT I - VISITS DATA								
	TITLE XVIII	- MEDICARE	TITLE XIX -	MEDICAID	OTI	IER	TO	TAL
		PATIENT		PATIENT		PATIENT		PATIENT
DESCRIPTION	VISITS 1	CENSUS 2	VISITS 3	CENSUS 4	VISITS 5	CENSUS 6	VISITS 7	CENSUS 8
1 Skilled Nursing Care - RN								
2 Skilled Nursing Care - LPN								
3 Physical Therapy								
4 Physical Therapy Assistant								
5 Occupational Therapy								
6 Certified Occupational Therapy Assistant								
7 Speech-Language Pathology								
8 Medical Social Service								
9 Home Health Aide								
10 All Other Services								
11 Total Visits								
12 Home Health Aide Hours								
13 Unduplicated Census Count								
15 Administrator and Assistant Administrator(s)			]		2	2	3	3
16 Director and Assistant Director(s)							<b> </b>	
17 Other Administrative Personnel							l	
18 Nursing Supervisor							ł	
19 Registered Nurses								
							1	
20 Licensed Practical Nurses								
20 Licensed Practical Nurses 21 Physical Therapy Supervisor								
21 Physical Therapy Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists								
<ol> <li>Physical Therapy Supervisor</li> <li>Physical Therapists</li> <li>Physical Therapy Assistants</li> <li>Occupational Therapy Supervisor</li> <li>Occupational Therapists</li> <li>Occupational Therapy Assistants</li> </ol>								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapy Supervisor         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapists         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor         32       Home Health Aides         33								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor         32       Home Health Aides         33       Home Health Aides								
21       Physical Therapy Supervisor         22       Physical Therapists         23       Physical Therapy Assistants         24       Occupational Therapy Supervisor         25       Occupational Therapists         26       Occupational Therapy Assistants         27       Speech-Language Pathology Supervisor         28       Speech-Language Pathologists         29       Medical Social Services Supervisor         30       Medical Social Services         31       Home Health Aide Supervisor		ere provided du	ring the cost re	porting period				1 . Codes

	CBSA Codes	
35 List all CBSA codes for areas where Medicare covered home health services were provided. (see instructions)		

35

09-20	FORM CM	S-1728-20			4795	(Cont.)
STATISTICAL DATA			HHA CCN:	PERIOD: FROM: TO:	WORKSHEET S-3 PART IV	
PART IV - PPS ACTIVITY DATA						
DESCRIPTION	FULL EPISODES/ PERIODS WITHOUT OUTLIERS	FULL EPISODES/ PERIODS WITH OUTLIERS 2	LUPA EPISODES/ PERIODS 3	PEP EPISODES/ PERIODS 4	TOTAL EPISODES/ PERIODS 5	
1 Skilled Nursing Care Visits						1
2 Skilled Nursing Care Charges						2
3 Physical Therapy Visits						3
4 Physical Therapy Charges						4
5 Occupational Therapy Visits						5
6 Occupational Therapy Charges						6
7 Speech-Language Pathology Visits						7
8 Speech-Language Pathology Charges						8
9 Medical Social Service Visits						9
10 Medical Social Service Charges						10
11 Home Health Aide Visits						11
12 Home Health Aide Charges						12
13 Total Visits (sum of lines 1, 3, 5, 7, 9, and 11)						13
14 Other Charges						14
15 Total Charges (sum of lines 2, 4, 6, 8, 10, 12, and 14)						15
16 Total Number of Episodes/Periods						16
17 Total Number of Outlier Episodes/Periods						17
18 Total Non-Routine Medical Supply Charges						18

ATISTICAL DATA RECT CARE EXPENDITURES       HHA CCN:       PERIDD: FROM:       WORKSHEET S-3 PART V         OCCUPATIONAL CATEGORY       1       2       3       AVERAGE HOURLY WAGE         AMOUNT REPORTED       BENEFTS       SALARIES       RELATED TO SALARY HOURLY WAGE       AVERAGE HOURLY WAGE         Nursing Occupations       1       2       3       4       5         2       8       4       5       4       5         2       8       4       5       4       5         2       8       4       5       4       5         2       Representation       2       4       5       4       5         3       1       2       3       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       5       4       4       4       4       4       4       4       4       4       4 <t< th=""><th>09-20</th></t<>	09-20					
STATISTICAL DATA DIRECT CARE EXPENDITURES			HHA CCN:	FROM:		
OCCUPATIONAL CATEGORY		BENEFITS	SALARIES		HOURLY WAGE	-
Direct Salaries	Ĩ	2			5	
						1
						2
3 Licensed Practical Nurses						3
						4
						5
6 Physical Therapists						6
						7
						8
						9
						10
						11
						12
13 Other Medical Staff						13
Contract Labor						
Nursing Occupations						
14 Nursing Supervisor						14
15 Registered Nurses						15
16 Licensed Practical Nurses						16
17 Total Nursing (sum of lines 14 through 16)						17
18 Physical Therapy Supervisor						18
19 Physical Therapists						19
20 Physical Therapy Assistants						20
21 Occupational Therapy Supervisor						21
22 Occupational Therapists						22
23 Occupational Therapy Assistants						23
24 Speech-Language Pathology Supervisor						24
25 Speech-Language Pathologists						25
26 Other Medical Staff						26

03-23	FORM (	479:	5 (Cont.)		
HHA-BASED HOSPICE STATISTICAL DATA		HHA CCN:	PERIOD:	WORKSHEET S-4	
			FROM:	PARTS I & II	
		HOSPICE CCN:	TO:		
PART I - ENROLLMENT DAYS					
		UNDUP	LICATED DAYS		
	TITLE XVIII	TITLE XIX			
	MEDICARE	MEDICAID	OTHER	TOTAL	
	1	2	3	4	
1 Hospice Continuous Home Care					1
2 Hospice Routine Home Care					2
3 Hospice Inpatient Respite Care					3
4 Hospice General Inpatient Care					4
5 Total Hospice Days					5
PART II - CONTRACTED STATISTICAL DATA					
	TITLE XVIII	TITLE XIX			
	MEDICARE	MEDICAID	OTHER	TOTAL	
	1	2	3	4	
6 Hospice Inpatient Respite Care					6
7 Hospice General Inpatient Care					7

4795	(Cont	t.)			FOR	M CMS-172	8-20					(	03-23
		ATION AND ADJUSTMENT OF TRIAL BALANC	E OF EXPENSES					HHA CCN:		PERIOD: FROM: TO:		WORKSHEET	A
			SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION	CON- TRACTED PURCHASED SERVICES	OTHER COSTS	TOTAL	RECLASSI- FICATION	RECLASSI- FIED TRIAL BALANCE	ADJUST- MENTS 9	EXPENSES FOR COST ALLOCATION	
		GENERAL SERVICE COST CENTERS	1	2	3	4	5	6	7	8	9	10	<u> </u>
1	0100												1
2	0100	Capital Related - Movable Equipment											2
2	0200	Plant Operation & Maintenance											3
	0300	Transportation (see instructions)											4
4	0400	Telecommunications Technology											5
5	0500	Administrative and General											6
7	0700	Nursing Administration											7
- /	0700	Medical Records	-					+	+	ł		+	8
8	0800	Wicultar Records	-					+	+	ł		+	8
9	0900	HHA REIMBURSABLE SERVICES											9
16	1600	Skilled Nursing Care - RN											16
10		Skilled Nursing Care - LPN											10
18		Physical Therapy											17
18		Physical Therapy Physical Therapy Assistant											18
20		Occupational Therapy											20
20		Certified Occupational Therapy Assistant											20
21		Speech-Language Pathology											21
	2200	Medical Social Services											22
23		Home Health Aide											23
24		Medical Supplies Charged to Patients						-					24
23		Drugs						-					25
20		Cost of Administering Vaccines						-					20
27		Durable Medical Equipment/Oxygen						-					27
28		Disposable Devices						-					28
30		Disposable Devices											30
30		HHA NONREIMBURSABLE SERVICES											30
20	3900	Home Dialysis Aide Services											39
	4000	Respiratory Therapy	-					+	1	<del> </del>		+	40
40		Private Duty Nursing	-					+	1	<del> </del>		+	40
41	4100	Clinic	-					+	+	ł		+	41
42		Health Promotion Activities	-					+	1	<del> </del>		+	42
43		Day Care Program						+		<u> </u>		+	43
44		Home Delivered Meals Program						+		<u> </u>		+	44
43		Homemaker Services		1	1			1	1	+		1	43
40		Telehealth (see instructions)											40
48	4800	Advertising						+					47
49		Fundraising											49
50		1 unurunning		1	1			1	1	+		1	50
50	5000	SPECIAL PURPOSE COST CENTERS											50
57	5700	Hospice											57
58	5800	nopree		1	1			1	1	+		1	58
100	5000	Total											100
100		1000							1				100

09-20				FORM CMS-1	728-20				4795	(Cont.)
RECLASSIFICATIONS						HHA CCN:	PERIO FROM TO:	D: :	WORKSHEET A-	6
	<u> </u>		INC	REASE			DEC	REASE		
			WS A				WS A	REASE		-
	CODE <sup>1</sup>	COST CENTER	LINE NO.	SALARY <sup>2</sup>	OTHER <sup>2</sup>	COST CENTER	LINE NO.	SALARY <sup>2</sup>	OTHER <sup>2</sup>	
EXPLANATION OF RECLASSIFICATION(S)	1	2	3	4	5	6	7	8	9	7
1							_			1 2
3										3
4										3
5										5
6 7			_				_			6 7
8				1						8
9										9
10										10
11	_		_							11
12 13			_				_			12 13
14										14
15										15
16			_							16
<u> </u>			_				_			17 18
19										19
20										20
21										21
22 23			_				_			22 23
24							_			23
25										25
			_				_			_
							-			-
										-
										+
							_			+
										+
100 TOTAL RECLASSIFICATIONS										100

<sup>1</sup> A letter (A, B, etc.) must be entered on each line to identify each reclassification entry. <sup>2</sup> Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 7, lines as appropriate.

DJUSTMENTS TO EXPENSES			PERIOD: FROM:	WORKSHEET A-8	
			- TO:		
				ASSIFICATION ON	
				TO/FROM WHICH	
	BASIS /			S TO BE ADJUSTED	
1	$CODE^2$	AMOUNT	COST CENTER	LINE NO.	
DESCRIPTION <sup>1</sup>	1	2	3	4	_
1 Excess funds generated from operations, other than net income					_
2 Trade, quantity, time and other discounts on purchases (chapter 8)					_
3 Rebates and refunds of expenses (chapter 8)					_
4 Related organization transactions (chapter 10)	WKST A-8-1				
5 Sale of medical records and abstracts					
6 Income from imposition of interest, finance or penalty charges					_
7 Sale of medical and surgical supplies to other than patients					_
8 Sale of drugs to other than patients					
9 Interest expense on Medicare overpayments and borrowings					1
to repay Medicare overpayments					╇
10 Lobbying activities (chapter 21)					_
11 Advertising costs (chapter 21)					╇
12					╇
13					_
14					_
15					
16					_
17					
18					_
19					
20					
21					
22					
23					
24					
25					
26					
27					
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33					
34					
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36					
37					
38					
39					
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41					
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44					
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46					
47					
48					
49					_

<sup>1</sup>Description - All line references in this column pertain to the CMS Pub. 15-1 <sup>2</sup>Basis for adjustment (see instructions)

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

09-20	FORM CMS-1728-20			4795 (Cont.)
COSTS OF SERVICES FROM RELATED ORGANIZATIONS		HHA CCN:	PERIOD:	WORKSHEET A-8-1
AND/OR HOME OFFICE/CHAIN ORGANIZATIONS			FROM:	
			TO:	

DIDT		THE PEOLIPER IS I PEOLIPEOPE			GULDIOR				
PART	I - ADJUSTI	MENTS REQUIRED AS A RESULT OF T	RANSACTIONS WITH RELATED ORGANIZATIONS AND/OR H	IOME OFFICE/					
					W/S S-2,	AMOUNT OF	AMOUNT INCLUDED		
	WKST A			PART II	PART I	ALLOWABLE	IN WKST. A,	NET	
	LINE NO.	COST CENTER	EXPENSE ITEM	LINE NO.	LINE NO.	COST	COL. 8	ADJUSTMENTS	
	1	2	3	4	5	6	7	8*	T
1									1
2									2
3									3
4									4
5									5
									T
50	TOTALS (s	sum of lines 1 through 49) Transfer col. 8, 1	ine 50, to Wkst. A-8, line 4, col. 2.						50

\* The amounts on lines 1 through 49 (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 organization or home office cost which have not been posted to Worksheet A, columns 1 through 5, the amount allowable should be indicated in column 6 of this section.

#### PART II - INTERRELATIONSHIP BETWEEN RELATED ORGANIZATIONS AND/OR HOME OFFICE/CHAIN ORGANIZATIONS

THE SECRECTARY, BY VIRTUE OF THE AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THE HHA TO FURNISH THE INFORMATION REQUESTED ON PART II OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS CONTRACTORS IN DETERMINING 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.

				RELATED ORGANIZATIONS AND/OR H	HOME OFFICE/CHAIN OR	GANIZATIONS	
			PERCENT OF		PERCENT OF	TYPE OF	
	SYMBOL <sup>1</sup>	NAME	OWNERSHIP	NAME	OWNERSHIP	BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
50							50

<sup>1</sup>Use the following symbols to indicate interrelationship to related organizations:

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

4795 (Cont.)		F	ORM CMS-1728-	-20				09-20
COST ALLOCATION ALLOCATION OF GENERAL SERVICE COSTS					HHA CCN:	PERIOD: FROM: TO:	WORKSHEET B	
	NET EXPENSES FOR COST ALLOCATION 0	CAP REL BLDGS & FIXTURES	CAP REL MOVABLE EQUIPMENT 2	PLANT OPERATION & MAINTENANCE 3	TRANS- PORTATION 4	SUBTOTAL 4A	TELE- COMMUN. TECHNOLOGY 5	
GENERAL SERVICE COST CENTERS	0	1	2	3	4	4A	5	
1 Capital Related - Buildings and Fixtures								1
2 Capital Related - Movable Equipment								2
3 Plant Operation & Maintenance								3
4 Transportation (see instructions)								4
5 Telecommunications Technology								5
6 Administrative and General								6
7 Nursing Administration								7
8 Medical Records			1					8
9 Other General Service	1 1		1	1	1			9
HHA REIMBURSABLE SERVICES								
16 Skilled Nursing Care - RN								16
17 Skilled Nursing Care - LPN								17
18 Physical Therapy								18
19 Physical Therapy Assistant								19
20 Occupational Therapy								20
21 Certified Occupational Therapy Assistant								21
22 Speech-Language Pathology								22
23 Medical Social Services								23
24 Home Health Aide								24
25 Medical Supplies Charged to Patients								25
26 Drugs								26
27 Cost of Administering Vaccines								27
28 Durable Medical Equipment/Oxygen								28
29 Disposable Devices								29
30								30
HHA NONREIMBURSABLE SERVICES								
39 Home Dialysis Aide Services								39
40 Respiratory Therapy								40
41 Private Duty Nursing								41
42 Clinic								42
43 Health Promotion Activities								43
44 Day Care Program								44
45 Home Delivered Meals Program								45
46 Homemaker Services								46
47 Telehealth								47
48 Advertising	_ <b>_</b>		ļ					48
49 Fundraising								49
50								50
SPECIAL PURPOSE COST CENTER								
57 Hospice								57
58								58
100 Total								100

09-2	0		F	ORM CMS-1728-	20			4795	(Cont.)
	ALLOCATION CATION OF GENERAL SERVICE COSTS					HHA CCN:	PERIOD: FROM: TO:	WORKSHEET B	
		SUBTOTAL	ADMINISTRA- TIVE & GENERAL	NURSING ADMINISTRA- TION	SUBTOTAL	MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
		5A	6	7	7A	8	9	10	
	GENERAL SERVICE COST CENTERS		· · ·	,		-			
1	Capital Related - Buildings and Fixtures								1
	Capital Related - Movable Equipment								2
	Plant Operation & Maintenance								3
4	Transportation (see instructions)								4
5	Telecommunications Technology								5
6	Administrative and General								6
7	Nursing Administration								7
8	Medical Records								8
9	Other General Service								9
	HHA REIMBURSABLE SERVICES								
16	Skilled Nursing Care - RN								16
	Skilled Nursing Care - LPN								17
	Physical Therapy								18
	Physical Therapy Assistant								19
20	Occupational Therapy								20
	Certified Occupational Therapy Assistant								21
	Speech-Language Pathology								22
23	Medical Social Services								23
	Home Health Aide								24
25	Medical Supplies Charged to Patients								25
	Drugs								26
	Cost of Administering Vaccines								27
	Durable Medical Equipment/Oxygen								28
	Disposable Devices								29
30									30
	HHA NONREIMBURSABLE SERVICES								
	Home Dialysis Aide Services								39
	Respiratory Therapy								40
	Private Duty Nursing								41
42					ļ				42
	Health Promotion Activities								43
	Day Care Program			ļ	ļ				44
	Home Delivered Meals Program		+	<u> </u>	l				45
	Homemaker Services								46
	Telehealth		+						47 48
	Advertising								48
	Fundraising		+						
50									50
	SPECIAL PURPOSE COST CENTER Hospice								57
58			+						58
	Total		+		<u> </u>				100
100	10001	<b>ļ</b>	1	ļ	I	ļ	<b>ļ</b>		100

	(Cont.)	ŀ	ORM CMS-1728-	20		DEDIOD	WORKGUEET D 1	09-20
	ALLOCATION STICAL BASES				HHA CCN:	PERIOD: FROM: TO:	WORKSHEET B-1	
	COST CENTER	CAP REL BLDGS & FIXTURES (SQUARE FEET)	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE) 2	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANS- PORTATION (MILEAGE) 4	RECONCIL- IATION	TELE- COMMUN. TECHNOLOGY (ACCUM. COST) 5	
	GENERAL SERVICE COST CENTER	1	2	3	4	5A	3	<u> </u>
	Capital Related - Buildings and Fixtures							1
	Capital Related - Movable Equipment							2
	Plant Operation & Maintenance							3
	Transportation (see instructions)							4
	Telecommunications Technology	1						5
	07		1					6
	Nursing Administration							7
	Medical Records							8
	Other General Service							9
	HHA REIMBURSABLE SERVICES							
	Skilled Nursing Care - RN							16
17	Skilled Nursing Care - LPN							17
	Physical Therapy							18
	Physical Therapy Assistant							19
20	Occupational Therapy							20
21								21
								22
								23
	Home Health Aide							24
	Medical Supplies Charged to Patients							2:
	Drugs							20
	Cost of Administering Vaccines							2'
	Durable Medical Equipment/Oxygen							2
	Disposable Devices							2
30								3
	HHA NONREIMBURSABLE SERVICES							3
	Home Dialysis Aide Services Respiratory Therapy							4
	Private Duty Nursing							4
			<del> </del>	1	+	+		4
	Health Promotion Activities		<u> </u>			+		42
	Day Care Program		1					42
	Home Delivered Meals Program		1					45
	Homemaker Services							4
	Telehealth		1	1				4
	Advertising							48
	Fundraising							49
50			İ					50
	SPECIAL PURPOSE COST CENTER							
	Hospice							57
58				1				58
	Cost To Be Allocated (per wkst B)							100
	Unit Cost Multiplier							101

09-20	)		F	ORM CMS-1728-	20			4795 (	(Cont.)
	ALLOCATION STICAL BASES					HHA CCN:	PERIOD: FROM: TO:	WORKSHEET B-1	
		RECONCIL- IATION	ADMINISTRA- TIVE & GENERAL (ACCUM. COST)	NURSING ADMINISTRA- TION (DIRECT NURS HRS)	RECONCIL- IATION	MEDICAL RECORDS (ACCUM. COST)	OTHER GENERAL SERVICE (SPECIFY)	TOTAL	
		6A	6	7	8A	8	9	10	
	GENERAL SERVICE COST CENTER								
1	Capital Related - Buildings and Fixtures								1
2	Capital Related - Movable Equipment								2
	Plant Operation & Maintenance								3
4	Transportation (see instructions) Telecommunications Technology					_			4
<u>5</u> 6	Administrative and General								6
7	Nursing Administration	+	+						7
	Medical Records								8
	Other General Service								9
	HHA REIMBURSABLE SERVICES								
16	Skilled Nursing Care - RN								16
	Skilled Nursing Care - LPN								17
	Physical Therapy								18
19	Physical Therapy Assistant								19
20	Occupational Therapy								20
21	Certified Occupational Therapy Assistant								21
22									22
	Medical Social Services								23
	Home Health Aide								24
25									25
									26
27									27
	Durable Medical Equipment/Oxygen								28
29	Disposable Devices								29
30	HHA NONREIMBURSABLE SERVICES						_		30
30	Home Dialysis Aide Services								39
									40
	Private Duty Nursing		1						41
42			1		t i i i i i i i i i i i i i i i i i i i				42
	Health Promotion Activities	1	İ		İ				43
	Day Care Program		1		i				44
45	Home Delivered Meals Program								45
	Homemaker Services								46
	Telehealth								47
									48
49	Fundraising								49
50	L								50
	SPECIAL PURPOSE COST CENTER								
	Hospice				<b> </b>				57
58	Cost To Do Allocated ( 1 ( D)								58
100	Cost To Be Allocated (per wkst B)								100
101	Unit Cost Multiplier								101

FORM CMS-1728-20 (09-2020) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4713)

Rev. 1

4795 (Cont.)			FO	RM CMS-172	8-20						09-20
APPORTIONMENT OF PATIENT SERVICE C	OSTS					HHA —	CCN:	PERIOD: FROM: TO:		WORKSHEET C PARTS I & II	
PART I - AGGREGATE HHA COST PER VISI	T AND AGGREGA	TE MEDICARE	COST COMPUTAT	ION							
COST PER VISIT COMPUTATION					FROM WKST. B, COL. 10,	TO	TAL	AVERAGE COST	HHA MEDICARE PROGRAM	HHA MEDICARE PROGRAM	
PATIENT SERVICES					LINE:	COST 2	VISITS 3	PER VISIT	VISITS 5	COSTS 6	-
1 Skilled Nursing Care - RN					16	-	5		U	Ű	1
2 Skilled Nursing Care - LPN					17						2
3 Physical Therapy					18						3
4 Physical Therapy Assistant					19						4
5 Occupational Therapy					20						5
6 Certified Occupational Therapy Assistant	t				21						6
7 Speech-Language Pathology					22						7
8 Medical Social Services					23						8
9 Home Health Aide Services 10 Total (sum of lines 1-9)					24						9
10 Total (sum of lines 1-9)											10
PART II - SUPPLIES, DRUGS, AND DISPOSA	BLE DEVICES CO	OST COMPUTAT	ION .								
,,,			[		MEDIC	ARE COVERED CI	HARGES	COST	OF MEDICARE SE	RVICES	
						HHA SE	ERVICES		HHA S	ERVICES	-
	FROM				OPPS	NOT SUBJECT	SUBJECT	OPPS	NOT SUBJECT	SUBJECT	1
	WKST. B,	TOTAL	TOTAL		REIMBURSED	TO DED &	TO DED &	REIMBURSED	TO DED &	TO DED &	
OTHER PATIENT SERVICES	COL. 10	COST	CHARGES	RATIO	SERVICES	COINSUR	COINSUR	SERVICES	COINSUR	COINSUR	
	LINE:	1	2	3	4	5	6	7	8	9	$\square$
11 Cost of Medical Supplies	25										11
12 Cost of Drugs	26										12
13 Cost of Administering Vaccines	27										13
14 Disposable Devices	29										14

04-24		FORM CMS-1728-20		479.	5 (Cont.)
CALCULA	ATION OF REIMBURSEMENT SETTLEMENT	HHA CCN:	PERIOD: FROM: TO:	WORKSHEET D	
PART I - O	COMPUTATION OF THE LESSER OF REASONABLE COST OR	CUSTOMARY CHARGES FOR VACCIN	VES		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
				2	
1	Reasonable cost of vaccines (see instructions)		1	2	1
2					2
3	Aggregate amount actually collected from patients liable for payme	ent for services on a			3
	charge basis (from your records)				1
4	Amount that would have been realized from patients liable for payr	nent for services on			4
	a charge basis had such payment been made in accordance with 42	CFR 413.13(e)			1
5	Ratio of line 3 to 4 (not to exceed 1.000000)				5
6	Total customary charges (multiply line 5 by line 2 for columns 1 and	d 2) (see instructions)			6
7	Excess of total customary charges over total reasonable cost (comp	lete only if			7
	line 6 exceeds line 1) (see instructions)				
8	Excess of reasonable cost over customary charges (see instructions	)			8
9	Subtotal of Reasonable Cost (see instructions)				9
PART II -	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
10	Total PPS payment - full episodes/periods without outliers				10
11	Total PPS payment - full episodes/periods with outliers				11
12	Total PPS payment - LUPA episodes/periods				12
13					13
14	Total PPS outlier payment - full episodes/periods with outliers				14
15					15
16	Total other payments (see instructions)				16
17	Payment for services reimbursed under OPPS				17
18					18
19	Oxygen Payment				19
20	Prosthetics and Orthotics Payment				20
21	Primary Payer Payments				21
22	Part B deductibles billed to Medicare patients (exclude coinsurance				22
23	Subtotal (sum of lines 9 through 15, plus lines 17 through 20, minu	s lines 16, 21, and 22)			23
24					24
25	Allowable bad debts (see instructions)				25
26	Adjusted reimbursable bad debts (see instructions)				26
27		s)			27
28	Subtotal (line 23 minus line 24, plus line 26)				28
29					29
30					30
31	Amount due HHA prior to sequestration adjustment (line 28 minus	lines 29 through 30)			31
32	Sequestration adjustment (see instructions)				32
32.75					32.75
33	Amount due HHA after sequestration adjustment (line 31 minus lin				33
34		on			34
35					35
36					36
37					37
38					38
39	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2, section 115.2			39

FORM CMS-1728-20 (04-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 4715 - 4715.2) Rev. 6

	'SIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO AM BENEFICIARIES	HHA CCN	:	PERIOD: FROM: TO:	WORKSHEET D-1	
				DATE	AMOUNT	
	DESCRIPTION			1	2	
1	Total interim payments paid to HHA					
2	Interim pymts payable on individual bills either submitted or to be submitted to the contractor, for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.					
3	List separately each retroactive lump sum		.01			
	adjustment amount based on subsequent revision	Program	.02			
	of the interim rate for the cost reporting period.	to	.03			
	Also show date of each payment. If none, write	Provider	.04			
	"NONE" or enter a zero. <sup>1</sup>		.05			
			.50			
		Provider	.51			
		to	.52			
		Program	.53			
			.54			
	SUBTOTAL (sum of lines 3.01 through 3.49, minus sum of lines 3.50 through 3.98)		.99			
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99)					
	(transfer to Worksheet D, Part II, line 36)					
	TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment	Program	.01			
	after desk review. Also show date of each	to	.02			
	payment. If none, write "NONE" or enter	Provider	.03			
	a zero. <sup>1</sup>	Provider	.50			
		to	.51			
		Program	.52			
-	SUBTOTAL (sum of lines 5.01 through 5.49, minus sum of lines 5.50 through 5.98)	1.5	.99			
6	Determine net settlement	Program	.01			
	amount (balance due) based on the cost report. '	to Describes				
	on the cost report.	Provider	02			
		Provider	.02			
		to Program				
7	TOTAL MEDICARE PROGRAM LIABILITY	6				
	(see instructions) NAME OF CONTRACTOR			RACTOR NUMBER	NPR DATE	

<sup>1</sup>On lines 3, 5 and 6, where an amount is due HHA to program, show the amount and date on which the HHA agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

01-24
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# FORM CMS-1728-20

01-24	t	FORM CM3-	1/20-20		4/95	(Cont.)
BALA	NCE SHEET		HHA CCN:	PERIOD: FROM: TO:	WORKSHEET F	
	ASSETS (Omit Cents)				AMOUNT	
	CURRENT ASSETS					
1	Cash on hand and in banks					1
	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable					4
5	Other receivables					5
6	Less: allowances for uncollectible notes and accounts receivable	ole				6
7	Inventory					7
8	Prepaid expenses					8
9	Other current assets					9
10	TOTAL CURRENT ASSETS (sum of lines 1 through 9)					10
	FIXED ASSETS					
11	Land					11
	Land Improvements					12
	Less: accumulated depreciation					13
	Buildings					13
	Less: accumulated depreciation					15
	Leasehold improvements					15
	Less: accumulated depreciation					10
	Fixed equipment					17
	Less: accumulated depreciation					19
	Automobiles and trucks					20
	Less: accumulated depreciation					21
22	Major movable equipment					22
	Less: accumulated depreciation					23
	Minor equipment					24
	Less: accumulated depreciation					25
	Minor equipment nondepreciable					26
	Other fixed assets					26.50
27	TOTAL FIXED ASSETS (sum of lines 11 through 26, and 26.	.50)				27
	OTHER ASSETS					
28	Investments					28
29	Deposits on leases					29
30	Due from owners/officers					30
30.50	Other assets					30.50
31	TOTAL OTHER ASSETS (sum of lines 28 through 30, and 30	0.50)				31
	TOTAL ASSETS (sum of lines 10, 27 and 31)					32
	•				•	
	LIABILITIES AND FUND BALANCE (Omit Cents)				AMOUNT	
-	CURRENT LIABILITIES					
33	Accounts payable					33
	Salaries, wages & fees payable					34
35	Payroll taxes payable					35
	Notes and payable loans (short term)					36
36						37
37	Deferred income					28
37 38	Deferred income Accelerated payments					38
37 38 39	Deferred income Accelerated payments Other current liabilities	0)				39
37 38 39	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3	9)				
37 38 39 40	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES	9)				39 40
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41     \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable	9)				39 40 41
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42     \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable	9)				39 40 41 42
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42 \\       43 \\       43       \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans	9)				39 40 41 42 43
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42 \\       43 \\       44     \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities					39 40 41 42 43 43 44
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42 \\       43 \\       44 \\       45 \\       \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities TOTAL LONG TERM LIABILITIES (sum of lines 41 throug					39 40 41 42 43 43 44 45
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42 \\       43 \\       44 \\       45 \\       \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities TOTAL LONG TERM LIABILITIES (sum of lines 41 throug TOTAL LIABILITIES (sum of lines 40 and 45)					39 40 41 42 43 44
$     \begin{array}{r}       37 \\       38 \\       39 \\       40 \\       41 \\       42 \\       43 \\       44 \\       45 \\       \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities TOTAL LONG TERM LIABILITIES (sum of lines 41 throug					$ \begin{array}{r} 39\\ 40\\ 41\\ 42\\ 43\\ 44\\ 45\\ 46\\ \end{array} $
$ \begin{array}{r} 37 \\ 38 \\ 39 \\ 40 \\ \hline 41 \\ 42 \\ 43 \\ \hline 44 \\ 45 \\ \hline 46 \\ \hline 47 \\ \end{array} $	Deferred income Accelerated payments Other current liabilities TOTAL CURRENT LIABILITIES (sum of lines 33 through 3 LONG TERM LIABILITIES Mortgage payable Notes payable Unsecured loans Other long term liabilities TOTAL LONG TERM LIABILITIES (sum of lines 41 throug TOTAL LIABILITIES (sum of lines 40 and 45)	th 44)				39 40 41 42 43 44 45

4795	(Cont.)	FORM CM	4S-1728-20			01-24
	MENT OF REVENUES AND EXPENSES		HHA CCN:	PERIOD: FROM: TO:	WORKSHEET F-1	
		TITLE XVIII				-
		MEDICARE	TITLE XIX	OTHER	TOTAL	
		MEDICARE 1	MEDICAID 2	OTHER 3	TOTAL 4	
1	Gross patient revenues	1	2	3	4	1
2	Less: Allowances and discounts on patients' accounts					2
3	Net patient revenues (line 1 minus line 2)					3
				1	2	
4	Operating expenses (from Wkst. A, line 100, col. 6)					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	Less total operating expenses (sum of lines 4 through 16)					17 18
18	Net income from service to patients (line 3 minus line 17) Other income:					18
19	Contributions, donations, bequests, etc.					19
20	Income (or loss) from investments					20
20	Purchase discounts					20
22	Rebates and refunds of expenses					22
23	Sale of Medical and Nursing Supplies to other than patients					23
24	Sale of durable medical equipment to other than patients					24
25	Sale of drugs to other than patients					25
26	Sale of medical records and abstracts					26
27	Government Appropriations					27
28						28
29						29
30						30
31						31
	COVID-19 PHE Funding					31.50
32	Total Other Income (sum of lines 19 through 31)					32
33	Net Income or Loss for the period (line 18 plus line 32)					33

09-20	)		4795 (Cont.)						
ANAL	YSIS OF HHA-BASED HOSPICE COSTS					HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O	
		SALARIES	OTHER 2	SUBTOTAL 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL	Γ
GENE	RAL SERVICE COST CENTERS	1	2	5		5	0	/	
	Cap Rel Costs-Bldg & Fixt*								
	Cap Rel Costs-Myble Equip*								2
	Employee Benefits Department*								3
	Administrative & General *				1				4
	Plant Operation & Maintenance*								5
	Laundry & Linen Service*								6
	Housekeeping*								7
	Dietary*								8
9	Nursing Administration*								9
	Routine Medical Supplies*								10
	Medical Records*								11
12	Staff Transportation*								12
	Volunteer Service Coordination*								13
14	Pharmacy*								14
15	Physician Administrative Services*								15
16	Other General Service*								16
17	Patient/Residential Care Services								17
DIREC	T PATIENT CARE SERVICE COST CENTERS								
	Inpatient Care-Contracted**								25
26	Physician Services**								26
	Nurse Practitioner**								27
	Registered Nurse**								28
	LPN/LVN**								29
	Physical Therapy**								30
	Occupational Therapy**								31
32	Speech-Language Pathology**								32
	Medical Social Services**								33
	Spiritual Counseling**								34
	Dietary Counseling**								35
	Counseling - Other**								36
	Hospice Aide & Homemaker Services**								37
	Durable Medical Equipment/Oxygen**								38
39	Patient Transportation**								39

\* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.

\*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

4795 (Cont.)	FORM CMS 1728-20											
ANALYSIS OF HHA-BASED HOSPICE COSTS					HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O					
							1					
	SALARIES	OTHER 2	SUBTOTAL	RECLASSI- FICATIONS	SUBTOTAL	ADJUST- MENTS 6	TOTAL					
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)	1	L	5	+	5	0	/					
40 Imaging Services**								40				
41 Labs & Diagnostics**								41				
42 Medical Supplies-Non-routine**								42				
43 Drugs Charged to Patients**								43				
44 Outpatient Services**								44				
45 Palliative Radiation Therapy**								45				
46 Palliative Chemotherapy**								46				
47 **								47				
NONREIMBURSABLE COST CENTERS												
60 Bereavement Program *								60				
61 Volunteer Program *								61				
62 Fundraising*								62				
63 Hospice/Palliative Medicine Fellows*								63				
64 Palliative Care Program*								64				
65 Other Physician Services*								65				
66 Residential Care *								66				
67 Advertising*								67				
68 Telehealth/Telemonitoring*								68				
69 Thrift Store*								69				
70 Nursing Facility Room & Board*								70				
71 *								71				
100 Total								100				

\* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

09-20		4795	(Cont.)					
ANALYSIS OF HHA-BASED HOSPICE COSTS CONTINUOUS HOME CARE					HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O-1 	
	SALARIES 1	OTHER 2	SUBTOTAL 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL 7	
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech-Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Drugs Charged to Patients								43
44 Outpatient Services								44
45 Palliative Radiation Therapy								45
46 Palliative Chemotherapy								46
47								47
100 Total *								100

\* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

4795 (Cont.)		28-20						
ANALYSIS OF HHA-BASED HOSPICE COST ROUTINE HOME CARE					HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O-2	
	SALARIES 1	OTHER 2	SUBTOTAL 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL 7	Τ
DIRECT PATIENT CARE SERVICE COST CENTERS								
25 Inpatient Care - Contracted								25
26 Physician Services								26
27 Nurse Practitioner								27
28 Registered Nurse								28
29 LPN/LVN								29
30 Physical Therapy								30
31 Occupational Therapy								31
32 Speech-Language Pathology								32
33 Medical Social Services								33
34 Spiritual Counseling								34
35 Dietary Counseling								35
36 Counseling - Other								36
37 Hospice Aide and Homemaker Services								37
38 Durable Medical Equipment/Oxygen								38 39
39 Patient Transportation								39
40 Imaging Services								40
41 Labs and Diagnostics								41
42 Medical Supplies-Non-routine								42
43 Drugs Charged to Patients								43
44 Outpatient Services								44
45 Palliative Radiation Therapy								45
46 Palliative Chemotherapy								46
47								47
100 Total *								100

\* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

09-20			4795 (						
ANALYSIS OF HHA-BASED HOSPICE COSTS INPATIENT RESPITE CARE				HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O-3			
	SALARIES 1	OTHER 2	SUBTOTAL 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL 7		
DIRECT PATIENT CARE SERVICE COST CENTERS									
25 Inpatient Care - Contracted								25	
26 Physician Services								26	
27 Nurse Practitioner								27	
28 Registered Nurse								28	
29 LPN/LVN								29	
30 Physical Therapy								30	
31 Occupational Therapy								31	
32 Speech-Language Pathology								32	
33 Medical Social Services								33	
34 Spiritual Counseling								34	
35 Dietary Counseling								35	
36 Counseling - Other								36	
37 Hospice Aide and Homemaker Services								37	
38 Durable Medical Equipment/Oxygen								38	
39 Patient Transportation								39	
40 Imaging Services								40	
41 Labs and Diagnostics								41	
42 Medical Supplies-Non-routine								42	
43 Drugs Charged to Patients								43	
44 Outpatient Services								44	
45 Palliative Radiation Therapy								45	
46 Palliative Chemotherapy								46	
47								47	
100 Total *								100	

\* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

4795 (C	Cont.)								
	IS OF HHA-BASED HOSPICE COSTS L INPATIENT CARE					HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O-4	
		SALARIES 1	OTHER 2	SUBTOTAL 3	RECLASSI- FICATIONS 4	SUBTOTAL 5	ADJUST- MENTS 6	TOTAL 7	Γ
DIRECT	PATIENT CARE SERVICE COST CENTERS								
25 In	patient Care - Contracted								25
26 Pł	nysician Services								26
27 N	urse Practitioner								27
28 R	egistered Nurse								28
29 LI	PN/LVN								29
30 Pł	nysical Therapy								30
	ccupational Therapy								31
32 S <sub>I</sub>	beech-Language Pathology								32
33 M	edical Social Services								33
34 S <sub>I</sub>	biritual Counseling								34
35 D	ietary Counseling								35
36 C	ounseling - Other								36
37 H	ospice Aide and Homemaker Services								37
38 D	urable Medical Equipment/Oxygen								38
39 Pa	atient Transportation								39
40 In	naging Services								40
	abs and Diagnostics								41
42 M	edical Supplies-Non-routine								42
	rugs Charged to Patients								43
44 O	utpatient Services								44
45 Pa	alliative Radiation Therapy								45
46 Pa	alliative Chemotherapy								46
47									47
100 Te	otal *								100

\* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

NATION OF HHA-BASED HOSPICE TOTAL EXPENSES OCATION Descriptions L SERVICE COST CENTERS up Rel Costs-Bldg & Fixt up Rel Costs-Mvble Equip mployee Benefits Department dministrative & General ant Operation & Maintenance undry & Linen Service undry & Linen Service	HHA CCN: HOSPICE CCN: HOSPICE CCN: DIRECT EXPENSES 1 1	PERIOD: FROM:	TOTAL EXPENSES 3	Ī
SERVICE COST CENTERS     p Rel Costs-Bldg & Fixt     p Rel Costs-Mvble Equip     mployee Benefits Department     dministrative & General     ant Operation & Maintenance     undry & Linen Service	HOSPICE DIRECT	GENERAL SERVICE EXPENSES FROM WKST B	EXPENSES	Ī
SERVICE COST CENTERS     p Rel Costs-Bldg & Fixt     p Rel Costs-Mvble Equip     mployee Benefits Department     dministrative & General     ant Operation & Maintenance     undry & Linen Service	DIRECT	SERVICE EXPENSES FROM WKST B	EXPENSES	I
SERVICE COST CENTERS     p Rel Costs-Bldg & Fixt     p Rel Costs-Mvble Equip     mployee Benefits Department     dministrative & General     ant Operation & Maintenance     undry & Linen Service	DIRECT	SERVICE EXPENSES FROM WKST B	EXPENSES	
SERVICE COST CENTERS p Rel Costs-Bldg & Fixt p Rel Costs-Mvble Equip mployee Benefits Department dministrative & General ant Operation & Maintenance nundry & Linen Service	DIRECT	EXPENSES FROM WKST B	EXPENSES	_
SERVICE COST CENTERS p Rel Costs-Bldg & Fixt p Rel Costs-Mvble Equip mployee Benefits Department dministrative & General ant Operation & Maintenance nundry & Linen Service				
p Rel Costs-Bldg & Fixt p Rel Costs-Mvble Equip mployee Benefits Department dministrative & General ant Operation & Maintenance undry & Linen Service				
p Rel Costs-Bldg & Fixt p Rel Costs-Mvble Equip mployee Benefits Department dministrative & General ant Operation & Maintenance undry & Linen Service				
nployee Benefits Department Iministrative & General ant Operation & Maintenance undry & Linen Service				1
Iministrative & General ant Operation & Maintenance undry & Linen Service				2
ant Operation & Maintenance nundry & Linen Service				3
undry & Linen Service				4
				5
ousekeening				6
Jusekeeping				7
etary				8
ursing Administration				9
outine Medical Supplies				10
edical Records				11
				12
				13
armacy				14
				15
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arsing Facility Koom & Board				70
acativa Cost Conton				71 99
				100
	ursing Administration butine Medical Supplies edical Records aff Transportation blunteer Service Coordination	etary spice Administration spice Administration spice Administration spice Administration spice Administrative Service Coordination armacy spician Administrative Services spice Administrative Services spice Continuous Home Care spice Continuous Home Care spice Routine Home Care spice Inpatient Respite Care spice General Inpatient Care IBURSABLE COST CENTERS reavement Program spice/Palliative Medicine Fellows lliative Care Program spice and spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Spice Centre Spice Center Spice Center Spice Center Spice Center Spice Center Spice Center Spice Center Spice Center Spice Center Spice Sp	etary control of the second se	etaryImage: standard strain strai

795 (Cont.) DST ALLOCATION - HHA-BASED HO LLOCATION OF HHA-BASED HOSPIC		CE COSTS		13-1728-20	HHA CCN:     PERIOD:       HOSPICE CCN:     FROM:						
	TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE- KEEPING	DIETARY	Ţ
	0	1	2	3	3A	4	5	6	7	8	┶
ENERAL SERVICE COST CENTERS											4
1 Cap Rel Costs-Bldg & Fixt	_			_							$\vdash$
2 Cap Rel Costs-Mvble Equip											
3 Employee Benefits Department											
4 Administrative & General	_							4			
5 Plant Operation & Maintenance	+										
6 Laundry & Linen Service										-	
7 Housekeeping	_										_
8 Dietary											_
9 Nursing Administration											
10 Routine Medical Supplies											
11 Medical Records											_
12 Staff Transportation											-
13 Volunteer Service Coordination											
<ul><li>14 Pharmacy</li><li>15 Physician Administrative Services</li></ul>											_
<ol> <li>Physician Administrative Services</li> <li>Other General Service</li> </ol>											
-											-
17 Patient/Residential Care Services											-
50 Hospice Continuous Home Care											-
											-
51 Hospice Routine Home Care				_						-	4
52 Hospice Inpatient Respite Care											+
53 Hospice General Inpatient Care											÷
ONREIMBURSABLE COST CENTERS											
<ul><li>60 Bereavement Program</li><li>61 Volunteer Program</li></ul>											
62 Fundraising											
62 Fundraising 63 Hospice/Palliative Medicine Fellows											-
64 Palliative Care Program	+			+							-
65 Other Physician Services											
66 Residential Care											-
67 Advertising											
67 Advertising 68 Telehealth/Telemonitoring											+
69 Thrift Store	+										
70 Nursing Facility Room & Board											+
70 Nursing Facility Room & Board 71	+										-
99 Negative Cost Center	+			+						+	+
100 Total											+

09-20				FORM CM	IS-1728-20						4795 (	(Cont.)
COST ALLOCATION - HHA-BASED HOS	SPICE GENERAL	SERVICE COSTS					HHA CCN:	:	PERIOD: FROM: TO:		WORKSHEET O PART I	<u> </u>
				000 - 1212							-	
	NURSING ADMINIS-	ROUTINE MEDICAL	MEDICAL RECORDS	STAFF TRANS-	VOLUNTEER SVC COOR-	PHARMA	CY PHYSI ADMINI		OTHER GENERAL	PATIENT / RESIDENTIAL	TOTAL	
	TRATION	SUPPLIES	RECORDS	PORTATION	DINATION		TIVES		SERVICE	CARE SVCS		
Descriptions	9	10	11	12	13	14	15		16	17	18	
GENERAL SERVICE COST CENTERS												
1 Cap Rel Costs-Bldg & Fixt												1
2 Cap Rel Costs-Mvble Equip												2
3 Employee Benefits Department												3
4 Administrative & General												4
5 Plant Operation & Maintenance	]											5
6 Laundry & Linen Service												6
7 Housekeeping	_											7
8 Dietary												8
9 Nursing Administration												9
10 Routine Medical Supplies												10
11 Medical Records												11
12 Staff Transportation												12
13 Volunteer Service Coordination												13
14 Pharmacy												14
15 Physician Administrative Services							_			-		15
16 Other General Service											-	16
17 Patient/Residential Care Services												17
LEVEL OF CARE 50 Hospice Continuous Home Care												50
51 Hospice Routine Home Care												51
51 Hospice Routine Home Care 52 Hospice Inpatient Respite Care												52
53 Hospice General Inpatient Care												53
NONREIMBURSABLE COST CENTERS												55
60 Bereavement Program												60
61 Volunteer Program												61
62 Fundraising												62
63 Hospice/Palliative Medicine Fellows												63
64 Palliative Care Program	1											64
65 Other Physician Services												65
66 Residential Care	1											66
67 Advertising												67
68 Telehealth/Telemonitoring												68
69 Thrift Store												69
70 Nursing Facility Room & Board												70
71												71
99 Negative Cost Center												99
100 Total												100

4795 (Cont.)	FORM CMS-1728-20										
COST ALLOCATION - HHA-BASED HOSPICE					HI	IA CCN:	PERIOD:		WORKSHEET O		
STATISTICAL BASES							FROM:		PART II		
					Но	OSPICE CCN:	TO:				
									_		
	CAP REL	CAP REL	EMPLOYEE		ADMINIS-	PLANT	LAUNDRY	HOUSE-	DIETARY		
	BLDG	MVBLE	BENEFITS		TRATIVE &		& LINEN	KEEPING			
	& FIX	EQUIP	DEPARTMENT		GENERAL	MAINT					
	(SQUARE	(DOLLAR	(GROSS	RECONCIL-	(ACCUM.	(SQUARE	(IN-FACIL-	(SQUARE	(IN-FACIL-		
	FEET)	VALUE)	SALARIES)	IATION	COST)	FEET)	ITY DAYS)	FEET)	ITY DAYS)		
Cost Center Descriptions	1	2	3	4A	4	5	6	7	8	_	
GENERAL SERVICE COST CENTERS						_			_	_	
1 Cap Rel Costs-Bldg & Fixt			-								
2 Cap Rel Costs-Mvble Equip				-						⊢	
3 Employee Benefits Department						-				<u> </u>	
4 Administrative & General										⊢	
5 Plant Operation & Maintenance 6 Laundry & Linen Service					<u> </u>					E -	
7 Housekeeping					ł	+			-	-	
8 Dietary											
9 Nursing Administration											
10 Routine Medical Supplies											
11 Medical Records										1	
12 Staff Transportation						-			1	1	
13 Volunteer Service Coordination										1	
14 Pharmacy										1	
15 Physician Administrative Services										j	
16 Other General Service										1	
17 Patient/Residential Care Services										1	
LEVEL OF CARE											
50 Hospice Continuous Home Care											
51 Hospice Routine Home Care											
52 Hospice Inpatient Respite Care											
53 Hospice General Inpatient Care											
NONREIMBURSABLE COST CENTERS											
60 Bereavement Program											
61 Volunteer Program										(	
62 Fundraising											
63 Hospice/Palliative Medicine Fellows										(	
64 Palliative Care Program										(	
65 Other Physician Services										(	
66 Residential Care										(	
67 Advertising											
68 Telehealth/Telemonitoring										e	
69 Thrift Store										6	
70 Nursing Facility Room & Board											
71											
99 Negative Cost Center					-					9	
101 Cost to be allocated					ļ					10	
102 Unit cost multiplier										10	

09-20				FORM CMS-	1728-20					4795 (	Cont.)
COST ALLOCATION - HHA-BASED	HOSPICE					]	HHA CCN:	PERIOD:		WORKSHEET	O-6
STATISTICAL BASES						_		FROM:		PART II	
						]	HOSPICE CCN:	TO:			
		·				T					-
	NURSING	ROUTINE	MEDICAL	STAFF	VOLUNTEER	PHARMAC		OTHER	PATIENT /		
	ADMINIS-	MEDICAL	RECORDS	TRANS-	SVC COOR-		ADMINISTRA-	GENERAL	RESIDENTIAL		
	TRATION	SUPPLIES		PORTATION	DINATION		TIVE SVCS	SERVICE	CARE SVCS		
	(DIRECT	(PATIENT	(PATIENT		(HOURS OF		(PATIENT	(SPECIFY	(IN-FACIL-		
	NURS. HRS.)	DAYS)	DAYS)	(MILEAGE)	SERVICE)	(CHARGE	<i>i i</i>	BASIS)	ITY DAYS)	TOTAL	
Cost Center Descriptions	9	10	11	12	13	14	15	16	17	18	
GENERAL SERVICE COST CENTER	S										
1 Cap Rel Costs-Bldg & Fixt											1
2 Cap Rel Costs-Mvble Equip											2
3 Employee Benefits Department											3
4 Administrative & General											4
5 Plant Operation & Maintenance											5
6 Laundry & Linen Service											6
7 Housekeeping											7
8 Dietary											8
9 Nursing Administration		Ī									9
10 Routine Medical Supplies			1								10
11 Medical Records				1							11
12 Staff Transportation					1						12
13 Volunteer Service Coordination											13
14 Pharmacy											14
15 Physician Administrative Services	3										15
16 Other General Service											16
17 Patient/Residential Care Services											17
LEVEL OF CARE											
50 Hospice Continuous Home Care											50
51 Hospice Routine Home Care											51
52 Hospice Inpatient Respite Care											52
53 Hospice General Inpatient Care											53
NONREIMBURSABLE COST CENTE	RS										33
60 Bereavement Program						-					60
61 Volunteer Program				<u> </u>	<u> </u>	<u> </u>					61
62 Fundraising											62
63 Hospice/Palliative Medicine Fello	wws					<u> </u>					63
64 Palliative Care Program					<u> </u>	<u> </u>					64
65 Other Physician Services						l					65
66 Residential Care											66
67 Advertising						l					67
68 Telehealth/Telemonitoring						<u> </u>					68
69 Thrift Store						<del> </del>					69
70 Nursing Facility Room & Board											70
70 Nursing Facility Room & Board											70
											99
99 Negative Cost Center											101
101 Cost to be allocated									+		
102 Unit cost multiplier			ļ								102

4795	(Cont.)

### FORM CMS-1728-20

APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

HOSPICE CCN:

PERIOD: FROM:

TO:

HHA CCN:

WORKSHEET O-7

	WKST. B, TOTAL TOTAL COST TO			COST TO	CHARGES BY LOC			SHARED SERVICE COSTS BY LOC				
	COL. 10,	HHA	HHA	CHARGE								
	LINE	COSTS	CHARGES	RATIO	HCHC	HRHC	HIRC	HGIP	HCHC	HRHC	HIRC	HGIP
Cost Center Descriptions	0	1	2	3	4	5	6	7	8	9	10	11
ANCILLARY SERVICE COST CENTERS												
Physical Therapy	18											
2 Physical Therapy Assistant	19											
3 Occupational Therapy	20											
4 Certified Occupational Therapy Assistant	21											
5 Speech-Language Pathology	22											
6 Medical Social Services	23											
7 Medical Supplies (see instructions)	25											1
8 Drugs	26											
Durable Medical Equipment/Oxygen	28											1
0 Totals (sum of lines 1-9)												1

04-21	FORM CMS-1728-20						
CALCULATION OF HHA-BASED HOS	SPICE PER DIEM COST	HHA CCN: HOSPICE CCN:	PERIOD: FROM: TO:	WORKSHEET O-8 			
		TITLE XVIII MEDICARE 1	TITLE XIX MEDICAID 2	TOTAL 3	T		
2 Total unduplicated days (Wkst. 3 Total average cost per diem (line	ol. 18, line 50 plus Wkst. O-7, col. 8, line 10) S-4, col. 4, line 1)				1 2 3 4		
5       Program cost (line 3 times line 4         HOSPICE ROUTINE HOME CARE         6       Total cost (Wkst. O-6, Part I, cc         7       Total unduplicated days (Wkst.         8       Total average cost per diem (line)	ol. 18, line 51 plus Wkst. O-7, col. 9, line 10) S-4, col. 4, line 2)				5 6 7 8		
10         Program cost (line 8 times line 9           HOSPICE INPATIENT RESPITE CAI           11         Total cost (Wkst. O-6, Part I, cc	RE ol. 18, line 52 plus Wkst. O-7, col. 10, line 10)				9 10 11		
12         Total unduplicated days (Wkst.           13         Total average cost per diem (lim           14         Unduplicated program days (Wł           15         Program cost (line 13 times line           HOSPICE         GENERAL           INPATIENT C/	e 11 divided by line 12) xst. S-4, col. as appropriate, line 3) 14)				12 13 14 15		
16       Total cost (Wkst. O-6, Part I, cc         17       Total unduplicated days (Wkst.         18       Total average cost per diem (linn         19       Unduplicated program days (WH)	bl. 18, line 53 plus Wkst. O-7, col. 11, line 10) S-4, col. 4, line 4) e 16 divided by line 17) <pre>(st. S-4, col. as appropriate, line 4)</pre>				16 17 18 19		
20       Program cost (line 18 times line         TOTAL       HOSPICE       CARE         21       Total cost (sum of line 1 + line 6         22       Total unduplicated days (Wkst.         23       Average cost per diem (line 21 det)	5 + line 11 + line 16) S-4, col. 4, line 5)				20 21 22 23		

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