ATTACHMENT 1

CMS FORM 1728-94

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE IN LIEU OF FORM CMS-1728-94-S (05-2007)
THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO FORM APPROVED
REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE OMB NO. 0938-0022
COST REPORTING PERIOD BEING DEEMED AS OVERPAYMENTS (42 USC 1395g).

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 99-9999	PERIOD: FROM 1/ 1/2008 TO 12/31/2008	WORKSHEET S

INTERMEDIARY USE ONLY:
[ ] AUDITED DATE RECEIVED / / [ ] INITIAL [ ] RE-OPENED
[ ] DESK REVIEWED INTERMEDIARY NUMBER [ ] FINAL

PART I - CERTIFICATION
CHECK APPLICABLE BOX [x] ELECTRONICALLY FILED COST REPORT DATE: 6/22/2009
[ ] MANUALLY SUBMITTED COST REPORT TIME: 11:50A

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

CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING HOME HEALTH AGENCY COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

MY HOME HEALTH CARE 999999

FOR THE COST REPORT PERIOD BEGINNING 01/01/2008 AND ENDING 12/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE REPORT 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.

ECR ENCRYPTION INFORMATION
DATE: 6/22/2009 TIME 11:50A

EyMKxNNGKTLgo2zLP7tdo6DcLYUfV0
QZd2S0FsBI4COZLl.scw5pP2bHweSC
XsRl0NnqxJ0fErcl

PI ENCRYPTION INFORMATION
DATE: 6/22/2009 TIME 11:50A
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Kk1D1Cfg9R0S9zvl

(SIGNED) _____
OFFICER OR DIRECTOR

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE XVIII PART A 1	TITLE XVIII PART B 2
1	HOME HEALTH AGENCY	0	-100
2	HOME HEALTH-BASED CORF	0	0
3	HOME HEALTH-BASED CMHC	0	0
3.50	HOME HEALTH-BASED RHC	0	0
3.60	HOME HEALTH-BASED FQHC	0	0
4	TOTAL	0	-100

"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 TO AVERAGE 226 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 REPORTS CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850."

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE

IN LIEU OF FORM CMS-1728-94-S (05-2007)
FORM APPROVED
OMB NO. 0938-0022

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORTING PERIOD BEING DEEMED AS OVERPAYMENTS (42 USC 1395g).

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 99-9999	PERIOD: FROM 1/ 1/2008 TO 12/31/2008	WORKSHEET S

INTERMEDIARY USE ONLY:
[ ] AUDITED
[ ] DESK REVIEWED

DATE RECEIVED / /
INTERMEDIARY NUMBER

[ ] INITIAL
[ ] FINAL

[ ] RE-OPENED

PART I - CERTIFICATION

CHECK APPLICABLE BOX
[X] ELECTRONICALLY FILED COST REPORT
[ ] MANUALLY SUBMITTED COST REPORT

DATE: 6/22/2009
TIME: 11:24A

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

CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING HOME HEALTH AGENCY COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:

MY HOME HEALTH CARE 999999

FOR THE COST REPORT PERIOD BEGINNING 01/01/2008 AND ENDING 12/31/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE REPORT 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 DIRECTOR

_____
TITLE

_____
DATE

PART II - SETTLEMENT SUMMARY

		TITLE XVIII PART A 1	TITLE XVIII PART B 2
1	HOME HEALTH AGENCY	0	-100
2	HOME HEALTH-BASED CORF	0	0
3	HOME HEALTH-BASED CMHC	0	0
3.50	HOME HEALTH-BASED RHC	0	0
3.60	HOME HEALTH-BASED FQHC	0	0
4	TOTAL	0	-100

"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 TO AVERAGE 226 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 REPORTS CLEARANCE OFFICER, MAIL STOP C4-26-05, BALTIMORE, MARYLAND 21244-1850."

HOME HEALTH AGENCY COMPLEX IDENTIFICATION DATA | PROVIDER NO: 99-9999 | PERIOD: FROM 1/ 1/2008 TO 12/31/2008 | PREPARED 6/22/2009 | WORKSHEET S-2

HOME HEALTH AGENCY COMPLEX ADDRESS:

1 STREET: 123 MAIN STREET P.O. BOX:

1.01 CITY: SOMEWHERE STATE: OH ZIP CODE: 99999-0000

HOME HEALTH AGENCY COMPONENT IDENTIFICATION:

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED
	0	1	2	2.01	3
2	HOME HEALTH AGENCY	MY HOME HEALTH CARE	99-9999		7/ 1/1966
3	HHA-BASED CORF				
4	HHA-BASED CMHC				
5	HHA-BASED RHC				
6	HHA-BASED FQHC				

7 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 1/ 1/2008 TO: 12/31/2008

8 TYPE OF CONTROL (SEE INSTRUCTIONS) 5

9 IF THIS IS A LOW OR NO MEDICARE UTILIZATION COST REPORT, ENTER "L" FOR LOW OR "N" FOR NO MEDICARE UTILIZATION.

DEPRECIATION: ENTER THE AMOUNT OF DEPRECIATION REPORTED IN THIS HHA FOR THE METHODS INDICATED.

10	STRAIGHT LINE	2,500
11	DECLINING BALANCE	0
12	SUM OF THE YEARS' DIGITS	0
13	SUM OF LINES 10, 11 AND 12	2,500

14	WERE THERE ANY DISPOSALS OF CAPITAL ASSETS DURING THIS COST REPORTING PERIOD?	N
15	WAS ACCELERATED DEPRECIATION CLAIMED ON ANY ASSETS IN THE CURRENT OR ANY PRIOR COST REPORTING PERIOD?	N
16	WAS ACCELERATED DEPRECIATION CLAIMED ON ASSETS ACQUIRED ON OR AFTER AUGUST 1, 1970 (SEE PRM 15-1, CHAPTER 1.)?	N
17	IF DEPRECIATION IS FUNDED, ENTER THE BALANCE AT END OF PERIOD.	0
18	DID THE PROVIDER CEASE TO PARTICIPATE IN THE MEDICARE PROGRAM AT THE END OF THE PERIOD TO WHICH THIS COST REPORT APPLIES (SEE PRM 15-1, CHAPTER 1)?	N
19	WAS THERE SUBSTANTIAL DECREASE IN HEALTH INSURANCE PROPORTION OF ALLOWABLE COSTS FROM PRIOR COST REPORTING PERIODS (SEE PRM 15-1, CHAPTER 1)?	N
20	DOES THE PROVIDER QUALIFY AS A SMALL HHA (DEFINED IN 42 CFR 413.24(d))?	N
21	DOES THE HOME HEALTH AGENCY QUALIFY AS A NOMINAL CHARGE PROVIDER (DEFINED IN 42 CFR 409.3)?	N
22	DOES THE HOME HEALTH AGENCY CONTRACT WITH OUTSIDE SUPPLIERS FOR PHYSICAL THERAPY SERVICES?	Y
22.01	DOES THE HOME HEALTH AGENCY CONTRACT WITH OUTSIDE SUPPLIERS FOR OCCUPATIONAL THERAPY SERVICES?	Y
22.02	DOES THE HOME HEALTH AGENCY CONTRACT WITH OUTSIDE SUPPLIERS FOR SPEECH THERAPY SERVICES?	Y

IF THIS FACILITY CONTAINS A NON-PUBLIC PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION.

		PART A	PART B
23	HOME HEALTH AGENCY	N	N
24	HHA-BASED CORF		N
25	HHA-BASED CMHC		N

26 IF THE HOME HEALTH AGENCY COMPONENTIZED (OR FRAGMENTED) ITS ADMINISTRATIVE AND GENERAL SERVICE COSTS, INDICATE WHETHER OPTION ONE OR OPTION TWO IS BEING UTILIZED. (SEE PRM-II, SECTION 3214) (ENTER "1" FOR OPTION ONE AND "2" FOR OPTION TWO)

27 List malpractice premiums and paid losses:

27.01	Premiums	2,500
27.02	Paid Losses	0
27.03	Self Insurance	0

28 Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? NO

If yes, submit a supporting schedule listing cost centers and amounts contained therein.

29 If you are part of a chain organization, enter "Y" for yes and enter the name and address of the home office, otherwise, enter "N" for no. N

29.01 Home Office Name: HOME OFFICE NO.: FI/CONTRACTOR NO.

29.02 Street : PO BOX:

29.03 City : State: Zip Code:

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE

IN LIEU OF FORM CMS-1728-94-S-3 (05-2007)

HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED 6/22/2009
99-9999	FROM 1/ 1/2008	WORKSHEET S-3
	TO 12/31/2008	

PART I - STATISTICAL DATA COUNTY ANYWHERE

		TITLE XVIII		OTHER		TOTAL	
		VISITS	PATIENTS	VISITS	PATIENTS	VISITS	PATIENTS
		1	2	3	4	5	6
1	00 SKILLED NURSING CARE	2,711	176	6,300	256	9,011	432
2	00 PHYSICAL THERAPY	1,435	100	1,632	63	3,067	163
3	00 OCCUPATIONAL THERAPY	517	53	629	26	1,146	79
4	00 SPEECH PATHOLOGY	267	15	226	10	493	25
5	00 MEDICAL SOCIAL SERVICES						
6	00 HOME HEALTH AIDE	1,179	43	9,688	88	10,867	131
7	ALL OTHER SERVICES			1,500	25	1,500	25
8	TOTAL VISITS (L1-7)	6,109		19,975		26,084	
9	HOME HEALTH AIDE HOURS	2,350		22,500		24,850	
10	UNDUPLICATED CENSUS COUNT		178.00		273.00		428.00

PART II - EMPLOYMENT DATA (FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

		STAFF	CONTRACT	TOTAL
		1	2	3
11	ADMINISTRATOR & ASSISTANT ADMINISTRATOR(S)	1.00		1.00
12	DIRECTOR & ASST. DIRECTOR(S)	1.00		1.00
13	OTHER ADMINISTRATIVE PERSONNEL	3.61		3.61
14	DIRECT NURSING SERVICE	7.98		7.98
15	NURSING SUPERVISOR			
16	PHYSICAL THERAPY SERVICE		1.47	1.47
17	PHYSICAL THERAPY SUPERVISOR			
18	OCCUPATIONAL THERAPY SERVICE		.55	.55
19	OCCUPATIONAL THERAPY SUPERVISOR			
20	SPEECH PATHOLOGY SERVICE		.24	.24
21	SPEECH PATHOLOGY SUPERVISOR			
22	MEDICAL SOCIAL SERVICE			
23	MEDICAL SOCIAL SUPERVISOR			
24	HOME HEALTH AIDE	11.94		11.94
25	HOME HEALTH AIDE SUPERVISOR			
26				
27				

PART III - METROPOLITAN STATISTICAL AREA (MSA) AND CORE BASED STATISTICAL AREA (CBSA) CODES

		1	1.01
28	ENTER THE TOTAL NUMBER OF MSAS IN COLUMN 1 AND/OR CBSAS IN COLUMN 1.01 WHERE MEDICARE COVERED SERVICES WERE PROVIDED DURING THE COST REPORTING PERIOD.		1

		MSA CODES	CBSA CODES
29	LIST ALL MSA AND CBSA CODES IN WHICH MEDICARE COVERED SERVICES WERE PROVIDED DURING THE COST REPORTING PERIOD (LINE 29 CONTAINS THE FIRST CODE)		99999

PART IV - PPS ACTIVITY DATA - APPLICABLE FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 2000

	DESCRIPTION	FULL EPISODES W/O OUTLIERS 1	FULL EPISODES W OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4	SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTALS 7
30	SKILLED NURSING VISITS	2,200	298	129	28			2,655
31	SKILLED NURSING VISIT CHARGES	198,000	26,820	11,610	2,520			238,950
32	PHYSICAL THERAPY VISITS	1,281	57	10	21			1,369
33	PHYSICAL THERAPY VISIT CHARGES	115,290	5,130	900	1,890			123,210
34	OCCUPATIONAL THERAPY VISITS	436	45	9	9			499
35	OCCUPATIONAL THERAPY VISIT CHARGES	39,240	4,050	810	810			44,910
36	SPEECH PATHOLOGY VISITS	27						27
37	SPEECH PATHOLOGY VISIT CHARGES	2,430						2,430
38	MEDICAL SOCIAL SERVICE VISITS							
39	MEDICAL SOCIAL SERVICE VISIT CHARGES							
40	HOME HEALTH AIDE VISITS	1,114	9	6	8			1,137
41	HOME HEALTH AIDE VISIT CHARGES	55,700	450	300	400			56,850
42	TOTAL VISITS (LNS 30,32,34,36,38,40)	5,058	409	154	66			5,687
43	OTHER CHARGES							
44	TOTAL CHARGES (31,33,35,37,39,41,43)	410,660	36,450	13,620	5,620			466,350
45	TOTAL NUMBER OF EPISODES	228		64	4			296
46	TOTAL NUMBER OF OUTLIER EPISODES		6					6
47	TOTAL NON-ROUTINE MED SUPPLY CHARGES	611	186	237				1,034

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | PROVIDER NO: 99-9999 | PERIOD: FROM 1/ 1/2008 TO 12/31/2008 | PREPARED 6/22/2009 WORKSHEET A

			COST CENTER	SALARIES 1	EMPLOYEE BENEFITS 2	TRANSPOR-TATION 3	CONTRACTED PURCHASED SVS 4	OTHER COSTS 5
			GENERAL SERVICE COST CTRS					
1	00	0100	CAP REL COSTS-BLDG & FIXT					48,000
2	00	0200	CAP REL COSTS-MVBLE EQUIP					7,500
3	00	0300	PLANT OPERATION AND MAINTENANCE					10,400
4	00	0400	TRANSPORTATION					
5	00	0500	ADMINISTRATIVE & GENERAL	229,680	39,796	2,500	26,400	173,842
			HHA REIMBURSABLE SERVICES					
6	00	0600	SKILLED NURSING CARE	385,265	66,755	39,019		
7	00	0700	PHYSICAL THERAPY				230,025	
8	00	0800	OCCUPATIONAL THERAPY				82,515	
9	00	0900	SPEECH PATHOLOGY				36,018	
10	00	1000	MEDICAL SOCIAL SERVICES					
11	00	1100	HOME HEALTH AIDE	274,638	47,586	37,915		
12	00	1200	SUPPLIES					
13	00	1300	DRUGS					
14	00	1400	DME					
			HHA NONREIMBURSABLE SVS					
15	00	1500	HOME DIALYSIS AIDE SERVICES					
16	00	1600	RESPIRATORY THERAPY					
17	00	1700	PRIVATE DUTY NURSING					
18	00	1800	CLINIC					
19	00	1900	HEALTH PROMOTION ACTIVITIES					
20	00	2000	DAY CARE PROGRAM					
21	00	2100	HOME DELIVERED MEALS PROGRAM					
22	00	2200	HOMEMAKER SERVICE					
23	00	2300	OTHER	28,026	4,856	9,150		
			SPECIAL PURPOSE COST CNTR					
24	00	2400	CORF					
25	00	2500	HOSPICE					
26	00	2600	CMHC					
27	00	2700	RHC					
28	00	2800	FQHC					
29	00		TOTAL	917,609	158,993	88,584	374,958	239,742

			COST CENTER	TOTAL 6	RECLASSI-FICATIONS 7	RECLASSIFIED TRIAL BALANCE 8	ADJUSTMENTS 9	EXP FOR COST ALLOCATION 10
			GENERAL SERVICE COST CTRS					
1	00	0100	CAP REL COSTS-BLDG & FIXT	48,000		48,000		48,000
2	00	0200	CAP REL COSTS-MVBLE EQUIP	7,500		7,500		7,500
3	00	0300	PLANT OPERATION AND MAINTENANCE	10,400		10,400		10,400
4	00	0400	TRANSPORTATION					
5	00	0500	ADMINISTRATIVE & GENERAL	472,218	-8,000	464,218	-13,150	451,068
			HHA REIMBURSABLE SERVICES					
6	00	0600	SKILLED NURSING CARE	491,039		491,039		491,039
7	00	0700	PHYSICAL THERAPY	230,025		230,025		230,025
8	00	0800	OCCUPATIONAL THERAPY	82,515		82,515		82,515
9	00	0900	SPEECH PATHOLOGY	36,018		36,018		36,018
10	00	1000	MEDICAL SOCIAL SERVICES					
11	00	1100	HOME HEALTH AIDE	360,139		360,139		360,139
12	00	1200	SUPPLIES		6,500	6,500		6,500
13	00	1300	DRUGS		1,500	1,500		1,500
14	00	1400	DME					
			HHA NONREIMBURSABLE SVS					
15	00	1500	HOME DIALYSIS AIDE SERVICES					
16	00	1600	RESPIRATORY THERAPY					
17	00	1700	PRIVATE DUTY NURSING					
18	00	1800	CLINIC					
19	00	1900	HEALTH PROMOTION ACTIVITIES					
20	00	2000	DAY CARE PROGRAM					
21	00	2100	HOME DELIVERED MEALS PROGRAM					
22	00	2200	HOMEMAKER SERVICE					
23	00	2300	OTHER	42,032		42,032		42,032
			SPECIAL PURPOSE COST CNTR					
24	00	2400	CORF					
25	00	2500	HOSPICE					
26	00	2600	CMHC					
27	00	2700	RHC					
28	00	2800	FQHC					
29	00		TOTAL	1,779,886	-0-	1,779,886	-13,150	1,766,736

	EXPLANATION OF RECLASSIFICATION	INCREASE CODE (1)	COST CENTER	LINE NO	AMOUNT(2)
		1	2	3	4
1	MEDICAL SUPPLIES	A	SUPPLIES	12	6,500
2	FLU VACCINES	B	DRUGS	13	1,500
30	TOTAL RECLASSIFICATIONS				8,000

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, column 7, lines as appropriate.

	EXPLANATION OF RECLASSIFICATION	DECREASE CODE (1)	COST CENTER	DECREASE LINE NO	DECREASE AMOUNT(2)
		1	5	6	7
1	MEDICAL SUPPLIES	A	ADMINISTRATIVE & GENERAL	5	6,500
2	FLU VACCINES	B	ADMINISTRATIVE & GENERAL	5	1,500
30	TOTAL RECLASSIFICATIONS				8,000

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
(2) Transfer to Worksheet A, column 7, lines as appropriate.

RECLASS CODE: A
EXPLANATION : MEDICAL SUPPLIES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT(2)	COST CENTER	LINE	AMOUNT(2)
1.00	SUPPLIES	12	6,500	ADMINISTRATIVE & GENERAL	5	6,500
TOTAL RECLASSIFICATIONS FOR CODE A			6,500			6,500

RECLASS CODE: B
EXPLANATION : FLU VACCINES

	INCREASE			DECREASE		
LINE	COST CENTER	LINE	AMOUNT(2)	COST CENTER	LINE	AMOUNT(2)
1.00	DRUGS	13	1,500	ADMINISTRATIVE & GENERAL	5	1,500
TOTAL RECLASSIFICATIONS FOR CODE B			1,500			1,500

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4
1	EXCESS FUNDS GEN FROM OPER, OTHER THAN NET INCOME	B			
2	TRADE, QUANTITY, TIME AND OTHER DISCOUNTS ON PURCHASES (CHAPTER 8)	B			
3	REBATES AND REFUNDS OF EXPENSES (CHAPTER 8)	B			
4	HOME OFFICE COSTS (CHAPTER 21)	A			
5	ADJUSTMENTS RESULTING FROM TRANSACTION WITH RELATED ORGANIZATION (CHAPTER 10)	A-6	-900		
6	SALE OF MEDICAL RECORDS AND ABSTRACTS	B			
7	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (CHAPTER 21)	B			
8	SALE OF MED AND SURG SUPPLIES TO OTHR THN PATIENTS	A			
9	SALE OF DRUGS TO OTHER THAN PATIENTS	A			
10	PHYSICAL THERAPY ADJUSTMENT (CHAPTER 14)	A-8-3		PHYSICAL THERAPY	7
10.1	OCCUPATIONAL THERAPY ADJUSTMENT (CHAPTER 14)	A-8-3		OCCUPATIONAL THERAPY	8
10.2	SPEECH PATHOLOGY ADJUSTMENT (CHAPTER 14)	A-8-3		SPEECH PATHOLOGY	9
11	INT EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS	A			
12	LOBBYING ACTIVITIES	A	-150	ADMINISTRATIVE & GENERAL	5
13	MISC INCOME	B	-2,400	ADMINISTRATIVE & GENERAL	5
14	PENALTIES	A	-100	ADMINISTRATIVE & GENERAL	5
15	MARKETING	A	-5,000	ADMINISTRATIVE & GENERAL	5
16	DONATIONS	A	-250	ADMINISTRATIVE & GENERAL	5
17	PERSONAL USE OF AUTO	A	-975	ADMINISTRATIVE & GENERAL	5
18	COST OF ALCOHOL	A	-125	ADMINISTRATIVE & GENERAL	5
19	KEY MAN INSURANCE	A	-500	ADMINISTRATIVE & GENERAL	5
20	BAD DEBT EXPENSE	A	-2,000	ADMINISTRATIVE & GENERAL	5
20.01	LOSS ON DISPOSAL OF ASSETS	A	-750	ADMINISTRATIVE & GENERAL	5
20.02					
20.03					
20.04					
20.05					
21	TOTAL		-13,150		

(1) Description - All line references in this column pertain to the Provider Reimbursement Manual, Part I.

(2) Basis for adjustment (See Instructions)

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

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE IN LIEU OF FORM CMS-1728-94-A-6 (05-2007)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

I PROVIDER NO: 99-9999 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 6/22/2009 I WORKSHEET A-6

A. ARE THERE ANY COSTS INCLUDED ON WORKSHEET A WHICH RESULTED FROM TRANSACTIONS WITH RELATED ORGANIZATIONS AS DEFINED IN CMS PUB. 15-I, CHAPTER 10?

X YES (IF "YES," COMPLETE PARTS B AND C)

NO

B. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS:

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 8

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT	AMOUNT ALLOWABLE IN COST	NET ADJUSTMENTS
1	2	3	4	5	6
1 5	ADMINISTRATIVE & GENERAL	SUPPLIES	5,000	4,100	900
2					
3					
3.01					
4	TOTALS		5,000	4,100	900

C. INTERRELATIONSHIP OF PROVIDER TO RELATED ORGANIZATION(S):

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

THE INFORMATION WILL BE USED BY THE CMS AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO THE PROVIDER BY COMMON OWNERSHIP OR CONTROL, REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT.
IF THE PROVIDER DOES NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT WILL BE CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	ADDRESS	PERCENT OWNED BY PROVIDER	PERCENT OWNERSHIP OF PROVIDER	TYPE OF BUSINESS
	1	2	3	4	5	6
1	A	MY SUPPLIES	SOMEWHERE, OH		100.00	SUPPLY COMPANY
2	A					
3						
4						
5						

(1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP OF THE PROVIDER 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 A 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:

ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCE

PROVIDER NO:	PERIOD:	PREPARED
99-9999	FROM 1/ 1/2008	WORKSHEET A-7
	TO 12/31/2008	

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIREMENTS	ENDING BALANCE
			PURCHASES	DONATIONS	TOTAL		
		1	2	3	4	5	6
1	LAND						
2	LAND IMPROVEMENTS						
3	BUILDINGS & FIXTURES						
4	BUILDING IMPROVEMENTS						
5	FIXED EQUIPMENT						
6	MOVABLE EQUIPMENT	25,000					25,000
7	TOTAL	25,000					25,000

		COST CENTER DESCRIPTION	NET EXPENSE FOR COST ALLOCATION	CAP REL COSTS -BLDG & FIXT	CAP REL COSTS -MVBLE EQUIP	PLANT OPERATION AND MAINT	TRANSPORTATION	SUBTOTAL	ADMINISTRATIVE & GENERAL
			0	1	2	3	4	4A	5
		GENERAL SERVICE COST CNTR							
1	00	CAP REL COSTS-BLDG & FIXT	48,000	48,000					
2	00	CAP REL COSTS-MVBLE EQUIP	7,500		7,500				
3	00	PLANT OPERATION AND MAINT	10,400			10,400			
4	00	TRANSPORTATION							
5	00	ADMINISTRATIVE & GENERAL	451,068	38,919	6,081	8,433		504,501	504,501
		HHA REIMBURSABLE SERVICES							
6	00	SKILLED NURSING CARE	491,039	6,486	1,014	1,405		499,944	199,822
7	00	PHYSICAL THERAPY	230,025					230,025	91,938
8	00	OCCUPATIONAL THERAPY	82,515					82,515	32,980
9	00	SPEECH PATHOLOGY	36,018					36,018	14,396
10	00	MEDICAL SOCIAL SERVICES							
11	00	HOME HEALTH AIDE	360,139	2,595	405	562		363,701	145,367
12	00	SUPPLIES	6,500					6,500	2,598
13	00	DRUGS	1,500					1,500	600
14	00	DME							
		HHA NONREIMBURS SERVICES							
15	00	HOME DIALYSIS AIDE SERVIC							
16	00	RESPIRATORY THERAPY							
17	00	PRIVATE DUTY NURSING							
18	00	CLINIC							
19	00	HEALTH PROMOTION ACTIVITI							
20	00	DAY CARE PROGRAM							
21	00	HOME DELIVERED MEALS PROG							
22	00	HOMEMAKER SERVICE							
23	00	OTHER	42,032					42,032	16,800
		SPEC PURPOSE COST CENTERS							
24	00	CORF							
25	00	HOSPICE							
26	00	CMHC							
27	00	RHC							
28	00	FQHC							
29	00	TOTAL	1,766,736	48,000	7,500	10,400		1,766,736	504,501

		COST CENTER DESCRIPTION	TOTAL
			6
		GENERAL SERVICE COST CNTR	
1	00	CAP REL COSTS-BLDG & FIXT	
2	00	CAP REL COSTS-MVBLE EQUIP	
3	00	PLANT OPERATION AND MAINT	
4	00	TRANSPORTATION	
5	00	ADMINISTRATIVE & GENERAL	
		HHA REIMBURSABLE SERVICES	
6	00	SKILLED NURSING CARE	699,766
7	00	PHYSICAL THERAPY	321,963
8	00	OCCUPATIONAL THERAPY	115,495
9	00	SPEECH PATHOLOGY	50,414
10	00	MEDICAL SOCIAL SERVICES	
11	00	HOME HEALTH AIDE	509,068
12	00	SUPPLIES	9,098
13	00	DRUGS	2,100
14	00	DME	
		HHA NONREIMBURS SERVICES	
15	00	HOME DIALYSIS AIDE SERVIC	
16	00	RESPIRATORY THERAPY	
17	00	PRIVATE DUTY NURSING	
18	00	CLINIC	
19	00	HEALTH PROMOTION ACTIVITI	
20	00	DAY CARE PROGRAM	
21	00	HOME DELIVERED MEALS PROG	
22	00	HOMEMAKER SERVICE	
23	00	OTHER	58,832
		SPEC PURPOSE COST CENTERS	
24	00	CORF	
25	00	HOSPICE	
26	00	CMHC	
27	00	RHC	
28	00	FQHC	
29	00	TOTAL	1,766,736

	COST CENTER DESCRIPTION	CAP REL COSTS -BLDG & FIXT (SQUARE FEET)	CAP REL COSTS -MVBLE EQUIP (SQUARE FEET)	PLANT OPERATION AND MAINT (SQUARE FEET)	TRANSPORTATION (MILEAGE)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COST)
		1	2	3	4	5A.00	5
	GENERAL SERVICE COST CNTR						
1	CAP REL COSTS-BLDG & FIXT	3,700					
2	CAP REL COSTS-MVBLE EQUIP		3,700				
3	PLANT OPERATION AND MAINT			3,700			
4	TRANSPORTATION						
5	ADMINISTRATIVE & GENERAL	3,000	3,000	3,000		-504,501	1,262,235
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	500	500	500			499,944
7	PHYSICAL THERAPY						230,025
8	OCCUPATIONAL THERAPY						82,515
9	SPEECH PATHOLOGY						36,018
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE	200	200	200			363,701
12	SUPPLIES						6,500
13	DRUGS						1,500
14	DME						
	HHA NONREIMBURS SERVICES						
15	HOME DIALYSIS AIDE SERVIC						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROMOTION ACTIVITI						
20	DAY CARE PROGRAM						
21	HOME DELIVERED MEALS PROG						
22	HOMEMAKER SERVICE						
23	OTHER						42,032
	SPEC PURPOSE COST CENTERS						
24	CORF						
25	HOSPICE						
26	CMHC						
27	RHC						
28	FQHC						
29	TOTAL	3,700	3,700	3,700			1,262,235
30	COST TO BE ALLOCATED (PER WORKSHEET B)	48,000	7,500	10,400			504,501
31	UNIT COST MULTIPLIER	12.972973	2.027027	2.810811			.399689

APPORTIONMENT OF PATIENT SERVICE COSTS | PROVIDER NO: 99-9999 | PERIOD: FROM 1/ 1/2008 TO 12/31/2008 | PREPARED 6/22/2009 | WORKSHEET C | PARTS I & II

PART I-AGGREGATE AGENCY COST PER VISIT COMPUTATION

COST PER VISIT COMPUTATION

	PATIENT SERVICES	FROM WKST B, COL. 6 LINE	TOTAL COSTS	TOTAL VISITS	AVERAGE COST PER VISIT (1)
		1	2	3	4
1 00	SKILLED NURSING CARE	6.00	699,766	9,011	77.66
2 00	PHYSICAL THERAPY	7.00	321,963	3,067	104.98
3 00	OCCUPATIONAL THERAPY	8.00	115,495	1,146	100.78
4 00	SPEECH PATHOLOGY	9.00	50,414	493	102.26
5 00	MEDICAL SOCIAL SERVICES	10.00			
6 00	HOME HEALTH AIDE	11.00	509,068	10,867	46.85
7 00	TOTAL		1,696,706	24,584	

PART II-COMPUTATION OF THE AGGREGATE MEDICARE COST AND THE AGGREGATE OF THE MEDICARE LIMITATION (2)

MSA/CBSA CODE: 99999

	TOTAL MEDICARE PATIENT SERVICE COST COMPUTATION	FROM WKST C PART I COL. 4 LINE	COST PER VISIT	MEDICARE PROGRAM VISITS PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE
			4	5	6	7
1 00	SKILLED NURSING CARE	1.00	77.66	1,655	1,000	
2 00	PHYSICAL THERAPY	2.00	104.98	869	500	
3 00	OCCUPATIONAL THERAPY	3.00	100.78	299	200	
4 00	SPEECH PATHOLOGY	4.00	102.26	27		
5 00	MEDICAL SOCIAL SERVICES	5.00				
6 00	HOME HEALTH AIDE	6.00	46.85	837	300	
7 00	TOTAL			3,687	2,000	

	TOTAL MEDICARE PATIENT SERVICE COST COMPUTATION	COST OF MEDICARE SERVICES PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL
		8	9	10	11
1 00	SKILLED NURSING CARE	128,527	77,660		206,187
2 00	PHYSICAL THERAPY	91,228	52,490		143,718
3 00	OCCUPATIONAL THERAPY	30,133	20,156		50,289
4 00	SPEECH PATHOLOGY	2,761			2,761
5 00	MEDICAL SOCIAL SERVICES				
6 00	HOME HEALTH AIDE	39,213	14,055		53,268
7 00	TOTAL	291,862	164,361		456,223

	TOTAL MEDICARE PATIENT SERVICE COST LIMITATION COMPUTATION (EFFECT. FOR PRE 10/1/2000 SERV ONLY)	PROGRAM COST LIMITS	MEDICARE PROGRAM VISITS PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE
		4	5	6	7
8 00	SKILLED NURSING CARE				
9 00	PHYSICAL THERAPY				
10 00	OCCUPATIONAL THERAPY				
11 00	SPEECH PATHOLOGY				
12 00	MEDICAL SOCIAL SERVICES				
13 00	HOME HEALTH AIDE				
14 00	TOTAL				

	TOTAL MEDICARE PATIENT SERVICE COST LIMITATION COMPUTATION (EFFECT. FOR PRE 10/1/2000 SERV ONLY)	COST OF MEDICARE SERVICES PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL
		8	9	10	11
8 00	SKILLED NURSING CARE				
9 00	PHYSICAL THERAPY				
10 00	OCCUPATIONAL THERAPY				
11 00	SPEECH PATHOLOGY				
12 00	MEDICAL SOCIAL SERVICES				
13 00	HOME HEALTH AIDE				
14 00	TOTAL				

(1)COMPUTE THE AVERAGE COST PER VISIT ONE TIME FOR EACH DISCIPLINE (COLUMN 4, LINES 1 THROUGH 6) FOR THE ENTIRE HOME HEALTH AGENCY.
(2)COMPLETE WORKSHEET C, PART II ONCE FOR EACH MSA WHERE MEDICARE COVERED SERVICES WERE FURNISHED DURING THE COST REPORTING PERIOD.

PART III-SUPPLIES AND DRUGS COST COMPUTATION

	OTHER PATIENT SERVICES	FROM WKST B, COL 6, LINE	TOTAL COST	TOTAL CHARGES (FROM HHA RECORD)	RATIO	MEDICARE COVERED CHARGES -- PART A	MEDICARE COVERED CHARGES -- PART B NOT SUBJ TO DEDUCTIBLES AND COINSURANCE PNEUM & FLU	MEDICARE COVERED CHARGES -- PART B SUBJECT TO DEDUCTIBLES & COINSURE
		1	2	3	4	5	6.01	7
15	SUPPLIES	12.00	9,098	13,000	.699846	6,000	6,400	
16	DRUGS	13.00	2,100	3,000	.700000		2,000	

	OTHER PATIENT SERVICES	COST OF SERVICES -- PART A	COST OF SERVICES -- PART B NOT SUBJ TO DEDUCTIBLES AND COINSURANCE PNEUM & FLU	COST OF SERVICES -- PART B SUBJECT TO DEDUCTIBLES & COINSURE
		8	9	9.01	10
15	SUPPLIES	4,199	4,479		
16	DRUGS		1,400		

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

	(EFFECTIVE FOR PRE 10/1/2000 SERVICE ONLY)	MEDICARE PER BENEFICIARY LIMITATION -- PROGRAM UNDUPLICATED CENSUS COUNT FOR EACH MSA (4)	MEDICARE PER BENEFICIARY LIMITATION -- ANNUAL PER MSA/ NON-MSA	COST OF MEDICARE SERVICES -- PART A	COST OF MEDICARE SERVICES -- PART B NOT SUBJECT TO DEDUCT & COINSURE	COST OF MEDICARE SERVICES -- PART B SUBJECT TO DEDUCT & COINSURE	TOTAL (SUM OF COLS 4 & 5
		1	2	3	4	5	6
17	TOTAL COST OF MEDICARE SERVICES			291,862	164,361		456,223
18	COST OF MEDICAL SUPPLIES			4,199	4,479		8,678
19	TOTAL			296,061	168,840		464,901
20	TOTAL COST PER VISIT LIMITATION FOR MEDICARE SERVICES						
21	COST OF MEDICAL SUPPLIES						
22	TOTAL						

	MSA CODE (3)	0	1	2	3	4	5	(COL 1 X 2) 6
23	PER BENEFICIARY COST LIMITATION FOR MSA:							
24	AGGREGATE PER BENEFICIARY							

PART V-OUTPATIENT THERAPY REDUCTION COMPUTATION

	PATIENT SERVICES	FROM WKST C, PART I, COL 4, LINE	AVERAGE COST PER VISIT	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE -- MEDICARE PRG VISITS FOR SRVS 1/1/98 BEFORE	MEDICARE PRG COST FOR SRVS 1/1/98 BEFORE	MEDICARE PRG VISITS FOR SRVS 1/1/98 - 12/31/98	MEDICARE PRG VISITS FOR SRVS 1/1/99 - 9/30/00	MEDICARE PRG VISITS FOR SRVS 10/1/00 ON / AFTER
		1	2	3	4	5	5.01	5.02
25	PHYSICAL THERAPY	2.00	104.98					
26	OCCUPATIONAL THERAPY	3.00	100.78					
27	SPEECH PATHOLOGY	4.00	102.26					
28	TOTAL							

	PATIENT SERVICES	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE -- MEDICARE APPLICATION PRG COST FOR SRVS 1/1/98 - 12/31/98	OF THE REASONABLE COST REDUCTION	REASONABLE COSTS NET OF ADJUSTMENTS
		6	7	8
25	PHYSICAL THERAPY			
26	OCCUPATIONAL THERAPY			
27	SPEECH PATHOLOGY			
28	TOTAL			

(3) THE MSA/CBSA CODES FLOW FROM WORKSHEET S-3, PART III, L II, LINE 29 AND SUBSCRIPTS AS INDICATED.
(4) THE SUM OF COLUMN 1, LINE 24 MUST EQUAL WORKSHEET S-3, PART I, COLUMN 2, LINE 10.01.

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

		PART A	PART B NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	PART B SUBJECT TO DEDUCTIBLES & COINSURANCE
		1	2	3
	REASONABLE COST OF TITLE XVIII - PART A AND PART B SERVICES			
1	REASONABLE COST OF SERVICES		1,400	
2	COST OF SERVICES, RHC & FQHC			
3	SUM OF LINES 1 AND 2		1,400	
4	TOTAL CHARGES FOR TITLE XVIII - PART A&B SERVICES PRE 10/01/2000			
4.01	TOTAL CHARGES FOR TITLE XVIII - PART A&B SERVICES POST 9/30/2000		2,000	
	CUSTOMARY CHARGES			
5	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
6	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
7	RATIO OF LINE 5 TO 6 (NOT TO EXCEED 1.0000)	1.000000	1.000000	1.000000
8	TOTAL CUSTOMARY CHARGES - TITLE XVIII		2,000	
9	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST		600	
10	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
11	PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

		PART A SERVICES 1	PART B SERVICES 2
12	TOTAL REASONABLE COST		1,400
12.01	TOTAL PPS PAYMENT - FULL EPISODES W/O OUTLIERS	347,317	252,953
12.02	TOTAL PPS PAYMENT - FULL EPISODES WITH OUTLIERS	9,906	11,058
12.03	TOTAL PPS PAYMENT - LUPA EPISODES	5,500	9,289
12.04	TOTAL PPS PAYMENT - PEP ONLY EPISODES	456	7,897
12.05	TOTAL PPS PAYMENT - SCIC WITHIN A PEP EPISODE		
12.06	TOTAL PPS PAYMENT - SCIC ONLY EPISODES		
12.07	TOTAL PPS OUTLIER PAYMENT-FULL EPISODES W OUTLIERS	2,839	2,392
12.08	TOTAL PPS OUTLIER PAYMENT - PEP ONLY EPISODES		
12.09	TOTAL PPS OUTLIER PAYMENT - SCIC IN A PEP EPISODE		
12.10	TOTAL PPS OUTLIER PAYMENT - SCIC ONLY EPISODES		
12.11	TOTAL OTHER PAYMENTS		
12.12	DME PAYMENT		
12.13	OXYGEN PAYMENT		
12.14	PROSTHETICS AND ORTHOTICS PAYMENT		
13	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS		
14	SUBTOTAL	366,018	284,989
15	EXCESS REASONABLE COST		
16	SUBTOTAL	366,018	284,989
17	COINSURANCE BILLED TO MEDICARE PATIENTS		
18	NET COST	366,018	284,989
19	REIMBURSABLE BAD DEBTS		
20	PNEUMOCOCCAL VACCINE		
21	TOTAL COSTS - CURRENT COST REPORTING PERIOD	366,018	284,989
22	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
23	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
24	UNREFUNDED CHARGES TO BENEFICIARIES FOR EXCESS COSTS ERRONEOUSLY COLLECTED BASED ON CORRECTION OF COST LIMIT		
25	TOTAL COST BEFORE SEQUESTRATION	366,018	284,989
25.50			
26	SEQUESTRATION ADJUSTMENT		
27	AMOUNT REIMBURSABLE AFTER SEQUESTRATION ADJUSTMENT	366,018	284,989
28	TOTAL INTERIM PAYMENTS	366,018	285,089
28.50	TENTATIVE SETTLEMENT		
29	BALANCE DUE HHA/MEDICARE PROGRAM		-100
30	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2		
31	BALANCE DUE PROVIDER/MEDICARE PROGRAM		-100

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE

IN LIEU OF FORM CMS-1728-94-D-1 (11-1998)

ANALYSIS OF PAYMENTS TO HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

PROVIDER NO:	PERIOD:	PREPARED 6/22/2009
99-9999	FROM 1/ 1/2008	WORKSHEET D-1
	TO 12/31/2008	

	DESCRIPTION			PART A		PART B	
				MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT
				1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER				366,018		285,089
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE".				NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)	PROGRAM TO PROVIDER	.01				
			.02				
			.03				
			.04				
			.05				
		PROVIDER TO PROGRAM	.50				
			.51				
			.52				
			.53				
			.54				
	SUBTOTAL		.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS				366,018		285,089
	TO BE COMPLETED BY INTERMEDIARY						
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)	PROGRAM TO PROVIDER	.01				
			.02				
			.03				
		PROVIDER TO PROGRAM	.50				
			.51				
			.52				
	SUBTOTAL		.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT	PROGRAM TO PROVIDER	.01				
		PROVIDER TO PROGRAM	.02				
7	TOTAL MEDICARE PROGRAM LIABILITY						

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE "PROVIDER TO PROGRAM," SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

LINE NO	ASSETS	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT ASSETS				
1	CASH ON HAND IN BANKS	12,500			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	124,000			
5	OTHER RECEIVABLES				
6	LESS:ALLOW FOR UNCL NOTES& ACCOUNT RECEIVABLE				
7	INVENTORY				
8	PREPAID EXPENSES	1,000			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	137,500			
	FIXED ASSETS				
12	LAND				
13	LAND IMPROVEMENTS				
14	LESS: ACCUMD DEPRECIATION				
15	BUILDINGS				
16	LESS: ACCUMD DEPRECIATION				
17	LEASEHOLD IMPROVEMENTS				
18	LESS: ACCUMD AMORTIZATION				
19	FIXED EQUIPMENT				
20	LESS: ACCUMD DEPRECIATION				
21	AUTOMOBILE AND TRUCKS				
22	LESS: ACCUMD DEPRECIATION				
23	MAJOR MOVABLE EQUIPMENT	25,000			
24	LESS: ACCUMD DEPRECIATION	-15,000			
25	MINOR EQUIPMENT NONDEPRECIABLE				
26	OTHER FIXED ASSETS				
27	TOTAL FIXED ASSETS	10,000			
	OTHER ASSETS				
28	INVESTMENTS				
29	DEPOSITS ON LEASES	500			
30	DUE FROM OWNERS/OFFICERS				
31	OTHER ASSETS				
32	TOTAL OTHER ASSETS	500			
33	TOTAL ASSETS	148,000			

LINE NO	LIABILITIES AND FUND BALANCES	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
	CURRENT LIABILITIES				
34	ACCOUNTS PAYABLE	15,000			
35	SAL, WAGES & FEES PAYABLE	35,000			
36	PAYROLL TAXES PAYABLE	5,000			
37	NTS & LOANS PAYABLE (SHORT TERM)	25,000			
38	DEFERRED INCOME				
39	ACCELERATED PAYMENTS				
40	DUE TO OTHER FUNDS				
41	OTHER CURRENT LIABILITIES	15,000			
42	TOTAL CURRENT LIABILITIES	95,000			
	LONG TERM LIABILITIES				
43	MORTGAGE PAYABLE				
44	NOTES PAYABLE				
45	UNSECURED LOANS				
46	LOANS PRIOR TO 7/1/66				
47	LOANS ON OR AFTER 7/1/66				
48	OTHER LONG TERM LIABILITIES				
49	TOTAL LONG TERM LIABILITIES				
50	TOTAL LIABILITIES	95,000			
	CAPITAL ACCOUNTS				
51	GENERAL FUND BALANCE	53,000			
52	SPECIFIC PURPOSE FUND BALANCE				
53	RESTRICT-ENDOWMENT FUND BALANCE				
54	UNRESTRICT-ENDOWMENT FUND BALANCE				
55	BOARD -ENDOWMENT FUND BALANCE				
56	PLANT-INVESTED IN PLANT				
57	PLANT-RESERVE FOR PLANT IMPROVEMEN REPLACEMENT AND EXPANSION				
58	TOTAL FUND BALANCES	53,000			
59	TOTAL LIABILITIES & FUND BALANCES	148,000			

Health Financial Systems MCRS/PC-WIN FOR MY HOME HEALTH CARE

IN LIEU OF FORM CMS-1728-94-F-1 (12-1994)

STATEMENT OF REVENUES AND EXPENSES

I PROVIDER NO: 99-9999 I PERIOD: I FROM 1/ 1/2008 I TO 12/31/2008 I PREPARED 6/22/2009 I WORKSHEET F-1

1	TOTAL PATIENT REVENUES	1,809,392	
2	LESS: ALLOW & DISCNT ON PATS ACCNTCOUNTS		
3	NET PATIENT REVENUES		1,809,392
4	OPERATING EXPENSES	1,779,886	
	ADDITIONS TO OPERATING EXPENSES (SPECIFY)		
5			
6			
7			
8			
9			
10			
	SUBTRACTIONS FROM OPERATING EXPENSES (SPECIFY)		
11			
12			
13			
14			
15			
16			
17	LESS TOTAL OPERATING EXPENSES		1,779,886
18	NET INCOME FROM SERVICE TO PATIENT		29,506
	OTHER INCOME:		
19	CONTRIB, DONATIONS, BEQUESTS, ETC		
20	INCOME FROM INVESTMENTS		
21	PURCHASE DISCOUNTS		
22	REBATES AND REFUNDS OF EXPENSES		
23	SALE OF MED/NURS SUP OTHER THAN PATIENTS		
24	SALE OF DUR MED EQP OTHER THAN PATIENTS		
25	SALE OF DRUGS TO OTHER THAN PATIENTS		
26	SALE OF MED RECORDS/ABSTRACTS		
	OTHER REVENUES (SPECIFY)		
27	MISCELLANEOUS INCOME	2,400	
28			
29			
30			
31			
32	TOTAL OTHER INCOME		2,400
33	NET INCOME(LOSS) FOR THE PERIOD		31,906

STATEMENT OF CHANGES IN FUND BALANCES

I PROVIDER NO: 99-9999 I PERIOD: FROM 1/ 1/2008 TO 12/31/2008 I PREPARED 6/22/2009 I WORKSHEET F-2 I

LINE NO		GENERAL FUND 1 & 2	SPECIFIC PURPOSE FUND 3 & 4	ENDOWMENT FUND 5 & 6	PLANT FUND 7 & 8
	CAPITAL ACCOUNTS				
1	FUND BALANCES AT BEG OF PERIOD OF PERIOD	21,094			
2	NET INCOME (LOSS)	31,906			
3	TOTAL (SUM OF LINES 1 & 2)	53,000			
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS(CR ADJUSTMENT)				
5					
6					
7					
8					
9	TOTAL ADDITIONS				
10	SUBTOTAL (LINE 3 PLUS LINE 9)	53,000			
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
11	DEDUCTIONS (DR ADJUSTMENTS)				
12					
13					
14					
15					
16	TOTAL DEDUCTIONS				
17	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	53,000			