ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM _____ TO _____

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES (from Wkst. H-1) *	EMPLOYEE BENEFITS * (from Wkst. H-2)	TRANSPOR-TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES (from Wkst. H-3)*	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		1	2	3	4	5	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS											
1	Capital Related-Bldgs. and Fixtures											1
2	Capital Related-Movable Equipment											2
3	Plant Operation & Maintenance											3
4	Transportation (see instructions)											4
5	Administrative and General											5
	HHA REIMBURSABLE SERVICES											
6	Skilled Nursing Care											6
7	Physical Therapy											7
8	Occupational Therapy											8
9	Speech Pathology											9
10	Medical Social Services											10
11	Home Health Aide											11
12	Supplies (see instructions)											12
13	Drugs											13
13.20	Cost of Administering Vaccines											13.20
14	DME											14
	HHA NONREIMBURSABLE SERVICES											
15	Home Dialysis Aide Services											15
16	Respiratory Therapy											16
17	Private Duty Nursing											17
18	Clinic											18
19	Health Promotion Activities											19
20	Day Care Program											20
21	Home Delivered Meals Program											21
22	Homemaker Service											22
23	All Others											23
24	Total (sum of lines 1-23)											24

* = For cost reporting periods beginning on or after 10/1/2000 Worksheets H-1, H-2, and H-3 are no longer applicable, the amounts in columns 1, 2, and 4 are to be input.
Column, 6 line 24 should agree with the Worksheet A, column 3, line 71, or subscript as applicable.

HHA COMPENSATION ANALYSIS
SALARIES AND WAGES

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-1

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related-Bldg. and Fixtures										1
2	Capital Related-Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (see instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	All Others										23
24	Totals (sum of lines 1-23)										

(1) Transfer the amounts in column 9 to Wkst. H, column 1

HHA COMPENSATION ANALYSIS
EMPLOYEE BENEFITS (PAYROLL RELATED)

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-2

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related-Bldg. and Fixtures										1
2	Capital Related-Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (see instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	All Others										23
24	Totals (sum of lines 1-23)										

(1) Transfer the amounts in column 9 to Wkst. H, column 2

HHA COMPENSATION ANALYSIS
CONTRACTED SERVICES/PURCHASED SERVICES

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H-3

		ADMINIS-TRATORS	DIRECTORS	CONSULTANTS	SUPERVISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTERS										
1	Capital Related-Bldg. and Fixtures										1
2	Capital Related-Movable Equipment										2
3	Plant Operation & Maintenance										3
4	Transportation (see instructions)										4
5	Administrative and General										5
	HHA REIMBURSABLE SERVICES										
6	Skilled Nursing Care										6
7	Physical Therapy										7
8	Occupational Therapy										8
9	Speech Pathology										9
10	Medical Social Services										10
11	Home Health Aide										11
12	Supplies										12
13	Drugs										13
14	DME										14
	HHA NONREIMBURSABLE SERVICES										
15	Home Dialysis Aide Services										15
16	Respiratory Therapy										16
17	Private Duty Nursing										17
18	Clinic										18
19	Health Promotion Activities										19
20	Day Care Program										20
21	Home Delivered Meals Program										21
22	Homemaker Service										22
23	All Others										23
24	Totals (sum of lines 1-23)										

(1) Transfer the amounts in column 9 to Wkst. H, column 4

COST ALLOCATION - HHA GENERAL SERVICE COST | PROVIDER NO.: _____ HHA NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET H-4, PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	TOTAL (cols. 4a + 5)	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
		0	1	2	3	4	4a	5	6	
	GENERAL SERVICE COST CENTERS									
1	Capital Related-Bldgs. and Fixtures									1
2	Capital Related-Movable Equipment									2
3	Plant Operation & Maintenance									3
4	Transportation (see instructions)									4
5	Administrative and General									5
	HHA REIMBURSABLE SERVICES									
6	Skilled Nursing Care									6
7	Physical Therapy									7
8	Occupational Therapy									8
9	Speech Pathology									9
10	Medical Social Services									10
11	Home Health Aide									11
12	Supplies (see instructions)									12
13	Drugs									13
13.20	Cost of Administering Vaccines									13.20
14	DME									14
	HHA NONREIMBURSABLE SERVICES									
15	Home Dialysis Aide Services									15
16	Respiratory Therapy									16
17	Private Duty Nursing									17
18	Clinic									18
19	Health Promotion Activities									19
20	Day Care Program									20
21	Home Delivered Meals Program									21
22	Homemaker Service									22
23	All Others									23
24	Totals (sum of lines 1-23)									24

COST ALLOCATION - HHA STATISTICAL BASIS | PROVIDER NO.: _____ HHA NO.: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET H-4, PART II

		CAPITAL RELATED COSTS		PLANT				
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	OPERATION & MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	
		1	2	3	4	5a	5	
	GENERAL SERVICE COST CENTERS							
1	Capital Related-Bldgs. and Fixtures							1
2	Capital Related-Movable Equipment							2
3	Plant Operation & Maintenance							3
4	Transportation (see instructions)							4
5	Administrative and General							5
	HHA REIMBURSABLE SERVICES							
6	Skilled Nursing Care							6
7	Physical Therapy							7
8	Occupational Therapy							8
9	Speech Pathology							9
10	Medical Social Services							10
11	Home Health Aide							11
12	Supplies (see instructions)							12
13	Drugs							13
13.20	Cost of Administering Vaccines							13.20
14	DME							14
	HHA NONREIMBURSABLE SERVICES							
15	Home Dialysis Aide Services							15
16	Respiratory Therapy							16
17	Private Duty Nursing							17
18	Clinic							18
19	Health Promotion Activities							19
20	Day Care Program							20
21	Home Delivered Meals Program							21
22	Homemaker Service							22
23	All Others							23
24	Total (sum of lines 1-23)							24
25	Cost To Be Allocated (per Worksheet H-4, Part I)							25
26	Unit Cost Multiplier							26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM_____
TO _____

WORKSHEET H-5, PART I

	HHA COST CENTER (omit cents)	From Wkst. H-4 Part I, col. 6, line	HHA TRIAL BALANCE (1)	OLD CAPITAL RELATED COSTS		NEW CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0-5)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
				BLDGS. & FIXTURES	MOVABLE EQUIPMENT	BLDGS. & FIXTURES	MOVABLE EQUIPMENT							
		line	0	1	2	3	4	5	5A	6	7	8	9	
1	Administrative and General	5												1
2	Skilled Nursing Care	6												2
3	Physical Therapy	7												3
4	Occupational Therapy	8												4
5	Speech Pathology	9												5
6	Medical Social Services	10												6
7	Home Health Aide	11												7
8	Supplies	12												8
9	Drugs	13												9
9.20	Cost of Administering Vaccines	13.20												9.20
10	DME	14												10
11	Home Dialysis Aide Services	15												11
12	Respiratory Therapy	16												12
13	Private Duty Nursing	17												13
14	Clinic	18												14
15	Health Promotion Activities	19												15
16	Day Care Program	20												16
17	Home Delivered Meals Program	21												17
18	Homemaker Service	22												18
19	All Others	23												19
20	Totals (sum of lines 1-19) (2)													20
21	Unit Cost Multiplier: column 27, line 1 divided by the sum of column 27, line 20 minus column 27, line 1, rounded to 6 decimal places.													21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 71.
(2) Columns 0 through 27, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 71.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER NO.: _____
HHA NO.: _____

PERIOD:
FROM_____
TO _____

WORKSHEET H-5,
PART I (CONT.)

	CORF COST CENTER (omit cents)	HOUSE KEEPING	DIETARY	CAFETERIA	MAIN-TENANCE OF PERSONNEL	NURSING ADMINIS-TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	NON-PHYSICIAN ANES-THETISTS	
		10	11	12	13	14	15	16	17	18	19	20	
1	Administrative and General												1
2	Skilled Nursing Care												2
3	Physical Therapy												3
4	Occupational Therapy												4
5	Speech Pathology												5
6	Medical Social Services												6
7	Home Health Aide												7
8	Supplies												8
9	Drugs												9
9.20	Cost of Administering Vaccines												9.20
10	DME												10
11	Home Dialysis Aide Services												11
12	Respiratory Therapy												12
13	Private Duty Nursing												13
14	Clinic												14
15	Health Promotion Activities												15
16	Day Care Program												16
17	Home Delivered Meals Program												17
18	Homemaker Service												18
19	All Others												19
20	Totals (sum of lines 1-19) (2)												20
21	Unit Cost Multiplier: column 27, line 1 divided by the sum of column 27, line 20 minus column 27, line 1, rounded to 6 decimal places.												21

(2) Columns 0 through 27, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 71.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-5, PART I (CONT.)

	HHA COST CENTER (omit cents)	NURSING SCHOOL	INTERNS & RESIDENTS SALARY AND FRINGES	INTERNS & RESIDENTS PROGRAM COSTS	PARAMEDICAL EDUCATION (SPECIFY)	SUBTOTAL (sum of cols. 5a-24)	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 25 ± 26)	ALLOCATED HHA A&G (see Part II)	TOTAL HHA COSTS	
		21	22	23	24	25	26	27	28	29	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
9	Drugs										9
9.20	Cost of Administering Vaccines										9.20
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
13	Private Duty Nursing										13
14	Clinic										14
15	Health Promotion Activities										15
16	Day Care Program										16
17	Home Delivered Meals Program										17
18	Homemaker Service										18
19	All Others										19
20	Totals (sum of lines 1-19) (2)										20
21	Unit Cost Multiplier: column 27, line 1 divided by the sum of column 27, line 20 minus column 27, line 1, rounded to 6 decimal places.										21

(2) Columns 0 through 27, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 71.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM_____ TO _____

WORKSHEET H-5, PART II

	HHA COST CENTER	OLD CAPITAL RELATED COST		NEW CAPITAL RELATED COST							
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	MAIN-TENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	
		1	2	3	4	5	6A	6	7	8	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
9	Drugs										9
9.20	Cost of Administering Vaccines										9.20
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
13	Private Duty Nursing										13
14	Clinic										14
15	Health Promotion Activities										15
16	Day Care Program										16
17	Home Delivered Meals Program										17
18	Homemaker Service										18
19	All Others										19
20	Totals (sum of lines 1-19)										20
21	Total cost to be allocated										21
22	Unit Cost Multiplier										22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM_____ TO _____

WORKSHEET H-5, PART II (CONT.)

	HHA COST CENTER	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE-KEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	MAIN-TENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINIS-TRATION (DIRECT NURS. HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		9	10	11	12	13	14	15	16	17	
1	Administrative and General										1
2	Skilled Nursing Care										2
3	Physical Therapy										3
4	Occupational Therapy										4
5	Speech Pathology										5
6	Medical Social Services										6
7	Home Health Aide										7
8	Supplies										8
9	Drugs										9
9.20	Cost of Administering Vaccines										9.20
10	DME										10
11	Home Dialysis Aide Services										11
12	Respiratory Therapy										12
13	Private Duty Nursing										13
14	Clinic										14
15	Health Promotion Activities										15
16	Day Care Program										16
17	Home Delivered Meals Program										17
18	Homemaker Service										18
19	All Others										19
20	Totals (sum of lines 1-19)										20
21	Total cost to be allocated										21
22	Unit Cost Multiplier										22

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

PROVIDER NO.: _____ HHA NO.: _____

PERIOD: FROM_____ TO _____

WORKSHEET H-5, PART II (CONT.)

	HHA COST CENTER	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE (SPECIFY)	NON-PHYSICIAN ANES-THETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SALARY & FRINGES (ASSIGNED TIME)	INTERNS & RESIDENTS PROGRAM COSTS (ASSIGNED TIME)	PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)	
		18	19	20	21	22	23	24	
1	Administrative and General								1
2	Skilled Nursing Care								2
3	Physical Therapy								3
4	Occupational Therapy								4
5	Speech Pathology								5
6	Medical Social Services								6
7	Home Health Aide								7
8	Supplies								8
9	Drugs								9
9.20	Cost of Administering Vaccines								9.20
10	DME								10
11	Home Dialysis Aide Services								11
12	Respiratory Therapy								12
13	Private Duty Nursing								13
14	Clinic								14
15	Health Promotion Activities								15
16	Day Care Program								16
17	Home Delivered Meals Program								17
18	Homemaker Service								18
19	All Others								19
20	Totals (sum of lines 1-19)								20
21	Total cost to be allocated								21
22	Unit Cost Multiplier								22

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H-6, Part I

Check applicable box [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION

	Cost Per Visit Computation Patient Services	Frp, Wkst. H-5, Part I, col. 29, line	Facility Costs (from Wkst. H-5, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	Program Visits			Cost of Services			Total Program Cost (sum of cols. 9-10)	
									Part B			Part B			
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			1	2	3	4	5	6	7	8	9	10	11	12	
1	Skilled Nursing Care	2													1
2	Physical Therapy	3													2
3	Occupational Therapy	4													3
4	Speech Pathology	5													4
5	Medical Social Services	6													5
6	Home Health Aide	7													6
7	Total (sum of lines 1-6)														7

	Limitation Cost Computation Patient Services	MSA No. (1)				Program Cost Limits	Program Visits			Cost of Services			Total Program Cost (sum of cols. 9-10)	
								Part B			Part B			
							Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1	2	3	4	5	6	7	8	9	10	11	12	
8	Skilled Nursing Care													8
9	Physical Therapy													9
10	Occupational Therapy													10
11	Speech Pathology													11
12	Medical Social Services													12
13	Home Health Aide													13
14	Total (sum of lines 8-13)													14

	Supplies and Drugs Cost Computations Other Patient Services	From Wkst. H-5, Part I, col. 29, line	Facility Costs (from Wkst. H-5, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services			
									Part B			Part B		
								Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1	2	3	4	5	6	7	8	9	10	11	
15	Cost of Medical Supplies	8												15
16	Cost of Drugs	9												16
16.20	Cost of Administering Vaccines	9.20												16.20

	Per Beneficiary Cost Limitation:	MSA No. (1)	Amount	
17	Program unduplicated census from Worksheet S-4 (see instructions) (2)			17
18	Per beneficiary cost limitation (from your fiscal intermediary)			18
19	Per beneficiary cost limitation (line 17 times line 18) (see instructions)			19

(1) The MSA numbers flow from Worksheet S-4, line 20, and subscripts as indicated should be relicated on lines 8-13 and 17-18.

(2) The sum of line 17 and subscripts thereof must equal Worksheet S-4, line 2, for the appropriate title.

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H-6, Parts II & III

Check applicable box [ ] Title V [ ] Title XVIII [ ] Title XIX

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
			1	2	3	4	
1	Physical Therapy	50				col. 2, line 2	1
2	Occupational Therapy	51				col. 2, line 3	2
3	Speech Pathology	52				col. 2, line 4	3
4	Cost of Medical Supplies	55				col. 2, line 15	4
5	Cost of Drugs	56				col. 2, line 16	5

PART III - OUTPATIENT THERAPY REDUCTION COMPUTATION

			Part B Services Subject to Deductibles and Coinsurance						
				Program Visits		Program Cost		Program	
		From Part I, col. 5	Cost Per Visit	Prior to 1/1/1998	From 1/1/1998 thru 12/31/1998	Prior to 1/1/1998	From 1/1/1998 thru 12/31/1998	Visits on or after 1/1/1999	
		1	2	2.01	3	3.01	4	5	
1	Physical Therapy	2							1
2	Occupational Therapy	3							2
3	Speech Pathology	4							3
4	Total (sum of lines 1-3)								4

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET H-7, Parts I & II

Check Applicable Box [ ] Title V [ ] Title XVIII [ ] Title XIX

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

	Description	Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1	2	3	
	Reasonable Cost of Part A & Part B Services				
1	Reasonable cost of services (see instructions)				1
2	Total charges				2
	Customary Charges				
3	Amount actually collected from patients liable for payment for services on a charge basis (from your records)				3
4	Amount 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)				4
5	Ratio of line 3 to line 4 (not to exceed 1.000000)				5
6	Total customary charges (see instructions)				6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)				7
8	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)				8
9	Primary payer amounts				9

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services	Part B Services	
		1	2	
10	Total reasonable cost (see instructions)			10
10.01	Total PPS Reimbursement - Full Episodes without Outliers			10.01
10.02	Total PPS Reimbursement - Full Episodes with Outliers			10.02
10.03	Total PPS Reimbursement - LUPA Episodes			10.03
10.04	Total PPS Reimbursement - PEP Episodes			10.04
10.05	Total PPS Reimbursement - SCIC within a PEP Episodes			10.05
10.06	Total PPS Reimbursement - SCIC Episodes			10.06
10.07	Total PPS Outlier Reimbursement - Full Episodes with Outliers			10.07
10.08	Total PPS Outlier Reimbursement - PEP Episodes			10.08
10.09	Total PPS Outlier Reimbursement - SCIC within a PEP Episodes			10.09
10.10	Total PPS Outlier Reimbursement - SCIC Episodes			10.10
10.11	Total Other Payments			10.11
10.12	DME Payments			10.12
10.13	Oxygen Payments			10.13
10.14	Prosthetic and Orthotic Payments			10.14
11	Part B deductibles billed to Medicare patients (exclude coinsurance)			11
12	Subtotal (sum of lines 10 thru 10.14 minus line 11)			12
13	Excess reasonable cost (from line 8)			13
14	Subtotal (line 12 minus line 13)			14
15	Coinsurance billed to program patients (from your records)			15
16	Net cost (line 14 minus line 15)			16
17	Reimbursable bad debts (from your records)			17
17.01	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			17.01
18	Total costs - current cost reporting period (line 16 plus line 17)			18
19	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			19
20	Recovery of excess depreciation resulting from agencies' termination or decrease in program utilization			20
21	Other adjustments (see instructions) (specify)			21
22	Subtotal (line 18 plus/minus lines 19 and 21 minus line 20)			22
23	Sequestration adjustment (see instructions)			23
24	Subtotal (line 22 minus line 23)			24
25	Interim payments (see instructions)			25
25.01	Tentative settlement (for fiscal intermediary use only)			25.01
26	Balance due provider/program (line 24 minus lines 25 and 25.01)			26
27	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			27

FORM CMS-2552-96 (5/2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3648.2)

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-8

	Description			Part A		Part B		
				mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
				1	2	3	4	
1	Total interim payments paid to provider							1
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" or enter a zero.							2
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)		.01					3.01
			.02					3.02
		Program to Provider	.03					3.03
			.04					3.04
			.05					3.05
			.50					3.50
			.51					3.51
		Provider to Program	.52					3.52
			.53					3.53
			.54					3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99					3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-7, Part II, column as appropriate, line 23)							4
	TO BE COMPLETED BY INTERMEDIARY							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01					5.01
			.02					5.02
			.03					5.03
		Provider to Program	.50					5.50
			.51					5.51
			.52					5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99					5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions)	Program to Provider	.01					6.01
		Provider to Program	.02					6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)							7

Name of Intermediary	Intermediary Number
Signature of Authorized Person	Date: Month, Day, Year

(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.