ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

PROVIDER CCN: _____ HHA CCN: _____

PERIOD: FROM _____ TO _____

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASS-IFICATIONS	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
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

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | PROVIDER CCN: _____ HHA CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET H-1 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
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 CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-1, PART II

		CAPITAL RELATED COSTS		PLANT			ADMINIS-	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	OPERATION & MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)	RECONCIL-IATION	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
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-1, Part I)							25
26	Unit Cost Multiplier							26

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART I

	HHA COST CENTER (omit cents)	From Wkst. H-1 Part I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS BLDGS. & FIXTURES	CAPITAL RELATED COSTS MOVABLE EQUIPMENT	EMPLOYEE BENEFITS *DEPARTMENT*	SUBTOTAL (cols. 0-4)	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			0	1	2	4	4A	5	6	7	8	
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
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 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.											21

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART I (CONT.)

	HHA 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	
		9	10	11	12	13	14	15	16	17	18	19	
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
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 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.												21

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, 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. 4a-23)	INTERN & RESIDENT COST & POST STEPDOWN ADJUSTMENTS	SUBTOTAL (cols. 23 ± 24)	ALLOCATED HHA A&G (see Part II)	TOTAL HHA COSTS	
		20	21	22	23	24	25	26	27	28	
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
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 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.										21

(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, PART II

	HHA COST CENTER	CAPITAL RELATED COST		EMPLOYEE BENEFITS *DEPARTMENT*		ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	OPERATION OF PLANT	
		BLDGS. & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	(GROSS SALARIES)	RECONCIL-IATION	(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	
		1	2	4	4A	5	6	7	
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
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 CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, 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)	
		8	9	10	11	12	13	14	15	16	
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
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 CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-2, 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		PARA-MEDICAL EDUCATION (SPECIFY) (ASSIGNED TIME)	
						SALARY & FRINGES (ASSIGNED TIME)	PROGRAM COSTS (ASSIGNED TIME)		
		17	18	19	20	21	22	23	
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
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 CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-3, Parts I & II

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

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

	Cost Per Visit Computation Patient Services	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, 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 Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	Total Program Cost (sum of cols. 9-10)	
		line	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 Service	6													5
6	Home Health Aide	7													6
7	Total (sum of lines 1-6)														7

	Limitation Cost Computation Patient Services	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	
		1	2	3	4	
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-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, 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 Part A	Program Covered Charges Part B Not Subject to Deductibles & Coinsurance	Program Covered Charges Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		line	1	2	3	4	5	6	7	8	9	10	11	
15	Cost of Medical Supplies	8												15
16	Cost of Drugs	9												16

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	66				col. 2, line 2	1
2	Occupational Therapy	67				col. 2, line 3	2
3	Speech Pathology	68				col. 2, line 4	3
4	Cost of Medical Supplies	71				col. 2, line 15	4
5	Cost of Drugs	73				col. 2, line 16	5

DRAFT FORM CMS-2552-10 4090 (Cont.)

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-4, 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
11	Total PPS Reimbursement - Full Episodes without Outliers			11
12	Total PPS Reimbursement - Full Episodes with Outliers			12
13	Total PPS Reimbursement - LUPA Episodes			13
14	Total PPS Reimbursement - PEP Episodes			14
15	Total PPS Outlier Reimbursement - Full Episodes with Outliers			15
16	Total PPS Outlier Reimbursement - PEP Episodes			16
17	Total Other Payments			17
18	DME Payments			18
19	Oxygen Payments			19
20	Prosthetic and Orthotic Payments			20
21	Part B deductibles billed to Medicare patients (exclude coinsurance)			21
22	Subtotal (sum of lines 10 thru 20 minus line 21)			22
23	Excess reasonable cost (from line 8)			23
24	Subtotal (line 22 minus line 23)			24
25	Coinsurance billed to program patients (from your records)			25
26	Net cost (line 24 minus line 25)			26
27	Reimbursable bad debts (from your records)			27
28	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28
29	Total costs - current cost reporting period (line 26 plus line 27)			29
30	Other adjustments (see instructions) (specify)			30
31	Subtotal (line 29 plus/minus line 30)			31
31.01	*Sequestration adjustment (see instructions)*			*31.01*
32	Interim payments (see instructions)			32
33	Tentative settlement (for contractor use only)			33
34	Balance due provider/program line 31 minus lines *31.01, 32 and 33*			34
35	Protested amounts (nonallowable cost report items) in accordance with CMS			35

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ HHA CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-5

	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	.03					3.03
		to	.04					3.04
		Provider	.05					3.05
			.50					3.50
			.51					3.51
		Provider	.52					3.52
		to	.53					3.53
		Program	.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-4, Part II, column as appropriate, line 32)							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	.01					5.01
		to	.02					5.02
		Provider	.03					5.03
		Provider	.50					5.50
		to	.51					5.51
		Program	.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
8	Name of Contractor	Contractor Number		NPR Date: Month, Day, Year				8

(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.