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).

FORM APPROVED
OMB NO. 0938-0022

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S

Intermediary Use Only:

[ ] Audited	Date Received	_____ [ ]	Initial	[ ] Re-opened
[ ] Desk Reviewed	Intermediary No.	_____ [ ]	Final	

PART I - CERTIFICATION

Check	[ ]	Electronically filed cost report	Date: _____
applicable box	[ ]	Manually submitted cost report	Time: _____

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 _____(Provider name(s) and number(s)) for the cost report beginning _____and ending _____, 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	PART B	
		1	2	
1	HOME HEALTH AGENCY			1
2	HOME HEALTH-BASED CORF			2
3	HOME HEALTH-BASED CMHC			3
3.5	HOME HEALTH-BASED RHC/FQHC (specify)			3.5
4	TOTAL			4

"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.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-2

Home Health Agency Complex Address:

1	Street:		P.O. Box:	1
1.01	City:	State:	Zip Code:	1.01

Home Health Agency Component Identification

	Component	Component Name	Provider No.	Date Certified	
	0	1	2	3	
2	Home Health Agency				2
3	HHA-based CORF				3
3.50	HHA-based Hospice				3.50
4	HHA-based CMHC				4
5	HHA- based RHC				5
6	HHA-based FQHC				6

7	Cost Reporting Period (mm/dd/yyyy)	From: _____	To: _____	7

8	Type of control (see instructions)		8

9	If this a low or no Medicare utilization cost report, enter "L" for Low or "N" for No Medicare Utilization.		9

Depreciation: Enter the amount of depreciation reported in this HHA for the methods indicated.

10	Straight Line		10
11	Declining Balance		11
12	Sum of the Years' Digits		12
13	Sum of lines 10, 11 and 12		13

14	Were there any disposals of capital assets during this cost reporting period?		14
15	Was accelerated depreciation claimed on any assets in the current or any prior cost reporting period?		15
16	Was accelerated depreciation claimed on assets acquired on or after August l, l970 (See PRM 15-1, Chapter l)?		16
17	If depreciation is funded, enter the balance at end of period.		17
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)?		18
19	Was there substantial decrease in health insurance proportion of allowable costs from prior cost reporting periods (See PRM 15-1, Chapter 1)?		19
20	Does the provider qualify as a small HHA (defined in 42 CFR 413.24(d))?		20
21	Does the home health agency qualify as a nominal charge provider (defined in 42 CFR 409.3)?		21
22	Does the home health agency contract with outside suppliers for physical therapy services?		22
22.01	Does the home health agency contract with outside suppliers for occupational therapy services?		22.01
22.02	Does the home health agency contract with outside suppliers for speech therapy services?		22.02

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	
		1	2	
23	Home Health Agency			23
24	CORF			24
25	CMHC			25
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)			26

27	List amounts of malpractice premiums and paid losses:			27
27.01	Premiums			27.01
27.02	Paid Losses			27.02
27.03	Self Insurance			27.03
28	Are malpractice premiums and/or paid losses reported in other than the Administrative and General cost center? If yes, submit a supporting schedule listing cost centers and amounts contained therein.			28
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.			29
29.01	Home Office Name:	Home Office No. :	FI/Contractor No. :	29.01
29.02	Street:	P.O. Box:	FI/MAC Name:	29.02
29.03	City:	State:	Zip Code:	29.03

FORM CMS 1728-94-S-2 (1-2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3204)

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-3 PARTS I - III

PART I - STATISTICAL DATA COUNTY _____

	DESCRIPTION	Title XVIII Visits	Title XVIII Patients	Other Visits	Other Patients	Total Visits	Total Patients	
		1	2	3	4	5	6	
1	Skilled Nursing							1
2	Physical Therapy							2
3	Occupational Therapy							3
4	Speech Pathology							4
5	Medical Social Service							5
6	Home Health Aide							6
7	All Other Services							7
8	Total Visits							8
9	Home Health Aide Hours							9
10	Unduplicated Census Count - Full Cost Reporting Period							10
10.01	Unduplicated Census Count - Pre 10/1/2000							10.01
10.02	Unduplicated Census Count - Post 9/30/2000							10.02

PART II - EMPLOYMENT DATA
(FULL TIME EQUIVALENT)

	Number of hours in your normal work week _____	Staff	Contract	Total	
		1	2	3	
11	Administrator and Assistant Administrator(s)				11
12	Director and Assistant Director(s)				12
13	Other Administrative Personnel				13
14	Direct Nursing Service				14
15	Nursing Supervisor				15
16	Physical Therapy Service				16
17	Physical Therapy Supervisor				17
18	Occupational Therapy Service				18
19	Occupational Therapy Supervisor				19
20	Speech Pathology Service				20
21	Speech Pathology Supervisor				21
22	Medical Social Service				22
23	Medical Social Supervisor				23
24	Home Health Aide				24
25	Home Health Aide Supervisor				25
26					26
27					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 2 where Medicare covered services were provided during the cost reporting period.			28
29	List all MSA and CBSA codes in which Medicare covered home health services were provided during the cost reporting period (line 29 contains the first code):	MSA Codes	CBSA Codes	29
				29.01
				29.02
				29.03
				29.04
				29.05
				29.06
				29.07
				29.08
				29.09

FORM CMS-1728-94 (5-2007) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3205)

HOME HEALTH AGENCY STATISTICAL DATA	PROVIDER NO.: _____	PERIOD: From: _____ To: _____	WORKSHEET S-3 PART IV

PART IV - PPS ACTIVITY DATA - Applicable for Services Rendered on or After October 1, 2000

	DESCRIPTION	Full Episodes without Outliers	Full Episodes with Outliers	LUPA Episodes	PEP Only Episodes	SCIC within a PEP	SCIC Only Episodes	Totals	
		1	2	3	4	5	6	7	
30	Skilled Nursing Visits								30
31	Skilled Nursing Visit Charges								31
32	Physical Therapy Visits								32
33	Physical Therapy Visit Charges								33
34	Occupational Therapy Visits								34
35	Occupational Therapy Visit Charges								35
36	Speech Pathology Visits								36
37	Speech Pathology Visit Charges								37
38	Medical Social Service Visits								38
39	Medical Social Service Visit Charges								39
40	Home Health Aide Visits								40
41	Home Health Aide Visit Charges								41
42	Total Visits (Sum of lines 30,32,34,36,38,40)								42
43	Other Charges								43
44	Total Charges (Sum of lines 31,33,35,37,39,41,43)								44
45	Total Number of Episodes								45
46	Total Number of Outlier Episodes								46
47	Total Non-Routine Medical Supply Charges								47

HHA-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-4

Check Applicable Box [ ] RHC [ ] FQHC

Clinic Address and Identification

1	Street:	1
1.01	City: State: Zip Code: County:	1.01
2	Designation (for FQHCs only) - Enter "R" for rural or "U" for urban	2

Source of Federal Funds:		Grant Award	Date	
		1	2	
3	Community Health Center (Section 330(d), PHS Act)			3
4	Migrant Health Center (Section 329(d), PHS Act)			4
5	Health Services for the Homeless (Section 340(d), PHS Act)			5
6	Appalachian Regional Commission			6
7	Look-Alikes			7
8	Other (specify)			8

Physician Information		Physician Name	Billing Number	
9	Physician(s) furnishing services at the clinic or under agreement (see instruction			9

		Physician Name	Hours of Supervision	
10	Supervisory physician(s) and hours of supervision during period (see instruction			10

11	Does the facility operate as other than an RHC or FQHC? If yes, indicate number of other operations in column 2 and list the other type(s) of operation(s) and hours on subscripts of line 12			11

Enter the clinic hours on line 12 and list the other type(s) of operation(s) and hours on subscripts of line 12. (1

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
		from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
12	Clinic															12
12.01	Specify:															12.01
12.02	Specify:															12.02
12.03	Specify:															12.03

(1) List hours of operation based on a 24 hour clock. For example, 8:30am is 0830, 5:30pm is 1730 and 12 midnight is 2400.

13	Has the facility been approved for an exception to the productivity standard			13
14	Is this a consolidated cost report as defined in CMS Pub. 27, section 508(D)? If yes, enter in column 2 the number of providers included in this report. List all provider names and numbers below			14
15	Provider name: _____ Provider number: _____			15
15.01	Provider name: _____ Provider number: _____			15.01
15.02	Provider name: _____ Provider number: _____			15.02
15.03	Provider name: _____ Provider number: _____			15.03
16	Are you claiming allowable and/or non-allowable GME costs as a result of "substantial payment" for interns and residents? If yes, enter the number of Medicare visits in column 2 performed by interns and residents and complete Worksheet RF-1, lines 20 and 27 as applicable			16

HOSPICE IDENTIFICATION DATA	PROVIDER NO.: _____ HOSPICE NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-5

PART I

	Enrollment Days	Title XVIII Unduplicated Days	Title XVIII Unduplicated Skilled Nursing Facility Days	Other Unduplicated Days	Total Unduplicated Days (sum of cols. 1 & 3)	
		1	2	3	4	
1	Continuous Home Care					1
2	Routine Home Care					2
3	Inpatient Respite Care					3
4	General Inpatient Care					4
5	Total Hospice Days					5

PART II

	Census Data	Title XVIII	Title XVIII Skilled Nursing Facility	Other	Total (sum of cols. 1 & 3)	
		1	2	3	4	
6	Number of Patients Receiving Hospice Care					6
7	Total Number of Unduplicated Continuous Care Hours Billable to Medicare					7
8	Average Length of Stay (line 5 divided by line 6)					8
9	Unduplicated Census Count					9

NOTE: Parts I & II, column 1 also includes the days reported in column 2.

HHA-BASED CORF STATISTICAL DATA	PROVIDER NO.: _____ CORF NO.: _____	PERIOD: From: _____ To: _____	SUPPLEMENTAL WORKSHEET S-6

	CORF TREATMENTS	Title XVIII		Other		Total		
		Treatments	Patients	Treatments	Patients	Treatments	Patients	
		1	2	3	4	5	6	
1	Skilled Nursing Care							1
2	Physical Therapy							2
3	Occupational Therapy							3
4	Speech Pathology							4
5	Medical Social Services							5
6	Respiratory Therapy							6
7	Psychological Services							7
8	All Other Service							8
9	Total Treatments (Sum of lines 1-8)							9

CORF - NUMBER OF EMPLOYEES (FULL TIME EQUIVALENT)

Enter the number of hours in your normal workweek _____

		Staff	Contract	Total	
		1	2	3	
10	Administrators and Assistant Administrators				10
11	Directors and Assistant Directors				11
12	Other Administrative Personnel				12
13	Direct Nursing Service				13
14	Nursing Supervisor				14
15	Physical Therapy Service				15
16	Physical Therapy Supervisor				16
17	Occupational Therapy Service				17
18	Occupational Therapy Supervisor				18
19	Speech Pathology Service				19
20	Speech Pathology Supervisor				20
21	Medical Social Service				21
22	Medical Social Supervisor				22
23	Respiratory Therapy Service				23
24	Respiratory Therapy Supervisor				24
25	Psychological Service				25
26	Psychological Service Supervisor				26
27					27
28					28