ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS

PROVIDER NO.: _____

HHA NO.: _____

PERIOD:
FROM _____
TO _____

WORKSHEET H

		SALARIES (FROM WKST. H-1)	EMPLOYEE BENEFITS (FROM WKST. H-2)	TRANSPORT-ATION (SEE INSTRUCTIONS)	CONTRACTED/ PURCHASED SRVS (FROM WKST. H-3)	OTHER COSTS	TOTAL HHA COST	
		1	2	3	4	5	6	
	GENERAL SERVICE COST CENTER							
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 - General -HHA							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	DME - Rented							12
13	DME - Sold							13
14	Supplies (See Instructions)							14
	HHA NONREIMBURSABLE SERVICES							
15	Respiratory Therapy							15
16	Private Duty Nursing							16
17	Clinic							17
18	Health Promotion Activities							18
19	Day Care Program							19
20	Home Delivered Meals Program							20
21	Homemaker Service							21
22								22
23								23
24								24
25	Total							25

COMPENSATION ANALYSIS SALARIES AND WAGES	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H - 1

		ADMINIS-TRATORS	DIRECTORS	CONSULT-ANTS	SUPER-VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
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 - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22											22
23											23
24											24
25	Total										25

(1) See Instructions

COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H - 2

		ADMINIS-TRATORS	DIRECTORS	CONSULT-ANTS	SUPER-VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
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 - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22											22
23											23
24											24
25	Total										25

(1) See Instructions

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 3541)

COMPENSATION ANALYSIS CONTRACTED SERVICES PURCHASED SERVICES	PROVIDER NO.:_____ HHA NO.:_____	PERIOD: FROM _____ TO _____	WORKSHEET H - 3

		ADMINIS-TRATORS	DIRECTORS	CONSULT-ANTS	SUPER-VISORS	NURSES	THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
		1	2	3	4	5	6	7	8	9	
	GENERAL SERVICE COST CENTER										
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 - General--HHA										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	DME - Rented										14
13	DME - Sold										13
14	Supplies (See Instructions)										14
	TITLE XVIII NONREIMBURSABLE SERVICES										
15	Respiratory Therapy										15
16	Private Duty Nursing										16
17	Clinic										17
18	Health Promotion Activities										18
19	Day Care Program										19
20	Home Delivered Meals Program										20
21	Homemaker Service										21
22	All Other										22
23											23
24											24
25	Total										25

(1) See Instructions

Form 3569

ALLOCATION OF H H A ADMINISTRATIVE AND GENERAL COSTS	PROVIDER NO.: _____ HHA NO.:_____	PERIOD: FROM_____ TO_____	WORKSHEET H - 4 PARTS I & II

PART I - ALLOCATION OF HHA ADMINISTRATIVE AND GENERAL COSTS

	Cost Center	From Wkst B. Part I, Col 18 Lines as Indicated		Shared Ancillary Costs, from Wkst H-4, Part II Lines as Indicated		Subtotal (Sum of Cols. 1 and 2)	Allocation of H H A A & G Costs	Total H H A Costs (Col. 3 + Col. 4)	
		1		2		3	4	5	
1	Administrative and General--HHA	37					( )	-0-	1
2	Skilled Nursing Care--HHA	38							2
3	Physical Therapy--HHA	39		1					3
4	Occupational Therapy--HHA	40		2					4
5	Speech Pathology--HHA	41		3					5
6	Medical Social Services--HHA	42							6
7	Home Health Aide--HHA	43							7
8	Durable Medical Equipment Rented--HHA	44							8
9	Durable Medical Equipment Sold--HHA	45							9
10	Medical Supplies Charged to Patients			4					10
11	Drugs Charged to Patients			5					11
12	Home Delivered Meals--HHA	46							12
13	Other Home Health Services--HHA	47		6 / 7					13
14	TOTAL (Sum of lines 1 thru 13)			8			-0-		14
15	BASIS FOR ALLOCATION (Sum of lines 2 thru 13)								15
16	UNIT COST MULTIPLIER (Line 1 divided by line 15)								16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED S N F DEPARTMENTS

	Cost Center	Total H H A Charges - From Provider Records	Cost/Charge Ratio Fr. Wkst. C. Col. 3, Lines as indicated		H H A Shared Ancillary Costs (Col. 1 X Col. 2)	Transfer Column 3 to Part I as indicated		
		1	2		3	4		
1	Physical Therapy		25			Col. 2, line 3		1
2	Occupational Therapy		26			Col. 2, line 4		2
3	Speech Pathology		27			Col. 2, line 5		3
4	Medical Supplies Charged to Patients		29			Col. 2, line 10		4
5	Drugs Charged to Patients		30			Col. 2, line 11		5
6	Dental Care (Title XIX Only)		31			Col. 2, line 13		6
7	Other Ancillary Service Cost		33			Col. 2, line 13		7
8	TOTAL					Col. 2, line 14		8

FORM CMS 2540-96 (07/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 3543 - 3543.2)

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: _____ HHA NO:	PERIOD: From: _____ To: _____	WORKSHEET H-5 PARTS I & II

Check One: [ ] Title V [ ] Title XVIII [ ] Title XIX

PART I - AGGREGATE AGENCY COST PER VISIT COMPUTATIOI

	Cost Per Visit Computation Patient Services	From Wkst H-4 Pt I, Col. 5, Line	Total Cost	Total Visits	Average Cost Per Visit (Cols 2 ÷ 3) (1)	
		1	2	3	4	
1	Skilled Nursing	*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 Services	*7*				6
7	Total (Sum of lines 1-6)					7

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

	Total Medicare Patient Service Cost Computation	Average Cost Per Visit From Part I Column 4 Line ___		Medicare Program Visits Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
	MSA Code: _____ *CBSA Code*		4	5	6	7	
1	Skilled Nursing - pre 10/1/2000	*1*					1
1.01	Skilled Nursing -post 9/30/2000	*1*					1.01
2	Physical Therapy - pre 10/1/2000	*2*					2
2.01	Physical Therapy - post 9/30/2000	*2*					2.01
3	Occupational Therapy - pre 10/1/2000	*3*					3
3.01	Occupational Therapy - post 9/30/2000	*3*					3.01
4	Speech Pathology - pre 10/1/2000	*4*					4
4.01	Speech Pathology - post 9/1/2000	*4*					4.01
5	Medical Social Services - pre 10/1/00	*5*					5
5.01	Medical Social Services - post 9/30/00	*5*					5.01
6	Home Health Aide Svcs pre 10/1/2000	*6*					6
6.01	Home Health Aide Svcs - post 9/30/00	*6*					6.01
7	Total (Sum of lines 1-6)						7

(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 Part II once for each SMSA where Medicare covered services were furnished during the cost reporting period.

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: _____ HHA NO:	PERIOD: From: _____ To: _____	WORKSHEET H-5 PART II (Cont.)

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

	Total Medicare Patient Service Cost Computation	Cost of Medicare Services			Total (Sum of Cols 8 & 9 Pre 10/01/2000	Total (Sum of Cols 8 & 9 Post 9/30/2000	
		Part A	Part B				
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance			
		8	9	10	11	11.01	
1	Skilled Nursing - pre 10/1/2000						1
1.01	Skilled Nursing -post 9/30/2000						1.01
2	Physical Therapy - pre 10/1/2000						2
2.01	Physical Therapy - post 9/30/2000						2.01
3	Occupational Therapy - pre 10/1/2000						3
3.01	Occupational Therapy - post 9/30/2000						3.01
4	Speech Pathology - pre 10/1/2000						4
4.01	Speech Pathology - post 9/1/2000						4.01
5	Medical Social Services - pre 10/1/00						5
5.01	Medical Social Services - post 9/30/00						5.01
6	Home Health Aide Svcs pre 10/1/2000						6
6.01	Home Health Aide Svcs - post 9/30/00						6.01
7	Total (Sum of lines 1-6)						7

(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 Part II once for each SMSA where Medicare covered services were furnished during the cost reporting period.

	Total Medicare Patient Service Cost Limitation Computation	Program Cost Limit	Medicare Program Visits			Cost of Medicare Services			Total (Sum of Cols 8 & 9	
			Part A	Part B Deductibles and Coinsurance		Part A	Part B Deductibles and Coinsurance			
				(Not Subject to)	(Subject to)		(Not Subject to)	(Subject to)		
		4	5	6	7	8	9	10	11	
8	Skilled Nursing									8
9	Physical Therapy									9
10	Occupational Therapy									10
11	Speech Pathology									11
12	Medical Social Services									12
13	Home Health Aide Svcs									13
14	Total (Sum of lines 8-13)									14

APPORTIONMENT OF PATIENT SERVICE COSTS

PROVIDER NO.: _____
HHA NO:

PERIOD:
From: _____
To: _____

WORKSHEET H-5
PART III

PART III - SUPPLIES AND DRUGS COST COMPUTATION

	Other Patient Services	From Wkst. H-4, Part I, Col. 5 Line -	Total HHA Cost	Total Charges from HHA Record)	Ratio (Col 2 ÷ 3)	Part A Covered Charges	Part B Charges		
							Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	3	4	5	6	7	
15	Cost of Medical Supplies-Pre 10/01/2000	*10*							15
15.01	Cost of Medical Supplies-Post 10/01/2000	*10*							15.01
16	Cost of Drugs-Pre 10/01/200	*11*							16
16.01	Cost of Drugs-Post 10/01/2000	*11*							16.01
17	Total								17

		Part A Cost of Services	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		8	9	10	
15	Cost of Medical Supplies - Pre 10/01/2000				15
15.01	Cost of Medical Supplies - Post 09/30/2000				15.01
16	Cost of Drugs-Pre 10/0/2000				16
16.01	Cost of Drugs-Post 10/01/2000				16.01
17	Total				17

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER NO.: _____ HHA NO:	PERIOD: From: _____ To: _____	WORKSHEET H-5 PARTS IV & V

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

		Medicare Program Unduplicated Census Count For Each MSA	Per Beneficiary Annual Limitation Pe MSA/Non-MSA (From your FI)	Cost of Medicre Services			Total (Sum of Columns 3 and 4)	
					Part B			
				Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		1	2	3	4	5	6	
18	Total Cost of Medicare Services (Sum of the amounts for each Whst. H-5 Part II, columns 8, 9 & 11, respectively, line1-6)(exclusive of subscripts)							18
19	Cost of Medical Supplies (From Part III, columns 8 and 9, line 15)(exclusive of subscripts)							19
20	Total (Sum of lines 18 and 19).							20
21	Total Cost Per Visit Limitation for Medicare Services (Sum of the amounts from each Wkst. H-5, Pt II, cols. 8 & 9 respectively, line 14)							21
22	Cost of Medical Supplies (From Part III, cols. 8 & 9, line 15)(exclusive of subscripts)							22
23	Total (Sum of lines 21 and 22)							23

		MSA Code	Medicare Program Unduplicated Census Count For Each MSA	Per Beneficiary Annual Limitation Pe MSA/Non-MSA (From your FI)	Cost of Medicare Services			Total (Sum of Columns 3 and 4)	
					Part B				
					Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		0	1	2	3	4	5	6	
24	Per Beneficiary Cost Limitation for MSA								24
24.01	Per Beneficiary Cost Limitation for MSA								24.01
24.02	Per Beneficiary Cost Limitation for MSA								24.02
24.03	Per Beneficiary Cost Limitation for MSA								24.03
24.04	Per Beneficiary Cost Limitation for MSA								24.04
24.05	Per Beneficiary Cost Limitation for MSA								24.05
24.06	Per Beneficiary Cost Limitation for MSA								24.06
24.07	Per Beneficiary Cost Limitation for MSA								24.07
24.08	Per Beneficiary Cost Limitation for MSA								24.08
24.09	Per Beneficiary Cost Limitation for MSA								24.09
25	Aggregate Per Beneficiary Cost Limitation (Sum of lines 24 and subscripts thereof)								25

PART V - OUTPATIENT THERAPY REDUCTION COMPUTATION

	Patient Services	From Part I, Col. 4 Line:	Average Cost Per Visit	Part B - Subject to Deductibles and Coinsurance							
				Medicare Program Visits for Services Before 1/1/98	Medicare Program Costs for Services Before 1/1/98	Medicare Program Visits for Services on & After 1/1/98	Medicare Program Visits for Services on & After 1/1/99	Medicare Program Costs for Services on & After 1/1/98	Application of the Reasonable Cost Reduction	Reasonable Costs Net of Adjustments	
		1	2	3	4	5	5.01	6	7	8	
26	Physical Therapy	2									26
27	Occupational Therapy	3									27
28	Speech Pathology	4									28
29	Total (Sum of lines 26-28)										29

FORM CMS-2540-96 (06/2001) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SEC. 3544)

CALCULATION OF H H A REIMBURSEMENT SETTLEMENT PART A & PART B SERVICES	PROVIDER NO.: _____ HHA NO.:	PERIOD: FROM_____ TO_____	WORKSHEET H-6 PARTS I & II

Check One: [ ] 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	
Reasonable Cost of Program		1	2	3	
1	Cost of Services (See Instructions)				1
2	Total program charges for title XVIII Part A and Part B Services - Pre 10/01/2000				2
2.01	Total program charges for title XVIII Part A and Part B Services - Post 9/30/2000				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 1 to 2 (Not to exceed 1.0000)				5
6	Total customary program charges (Line 5 X line 2 - each column)				6
7	Primary Payor Amounts				7

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	Description	Part A Services 1	Part B Services 2	
8	Lesser of Cost or Charges (See Instructions)			8
8.01	Total PPS Reimbursement - Full Episodes without Outliers			8.01
8.02	Total PPS Reimbursement - Full Episodes with Outliers			8.02
8.03	Total PPS Reimbursement - LUPA Episodes			8.03
8.04	Total PPS Reimbursement - PEP Episodes			8.04
8.05	Total PPS Reimbursement - SCIC within a PEP Episode			8.05
8.06	Total PPS Reimbursement - SCIC Episodes			8.06
8.07	Total PPS Outlier Reimbursement - Full Episodes with Outliers			8.07
8.08	Total PPS Outlier Reimbursement - PEP Episodes			8.08
8.09	Total PPS Outlier Reimbursement - SCIC within a PEP Episode			8.09
8.10	Total PPS Outlier Reimbursement - SCIC Episodes			8.10
8.11	Total Other Payments			8.11
8.12	DME Payment			8.12
8.13	Oxygen ayment			8.13
8.14	Prosthetics and Orthotic Payment			8.14
9	Part B deductibles billed to Medicare patients (exclude coinsurance)			9
10	Subtotal (Line 8 minus line 9)			10
11	Coinsurance billed to Program patients (From your records)			11
12	Net cost (Line 10 minus line 11)			12
13	Reimbursable bad debts (From your records)			13
14	Total Costs - Current cost reporting period (Line 12 plus line 13)			14
15	Amounts applicable to prior cost reporting periods resulting from disposition of depreciable assets			15
16	Recovery of excess depreciation resulting from agencies termination or decrease in Program utilization			16
17	Unrefunded charges to beneficiaries for excess costs erroneously collected based on correction of cost limit			17
18	Total cost - before sequestration & other Adjustments (Line 14, minus the sum of lines 16 and 17 plus or minus the amount on line 15)			18
18.01	Other adjustments (see instructions) (Specify)			18.01
19	Sequestration Adjustment (See Instructions)			19
20	Amount due to you after sequestration adjustment & other adjustments (Line 18 plus line 18.01 minus line 19)			20
21	Total interim payments (From Worksheet H-7, line 4)			21
21.01	Tentative Settlement (For Intermediary Use Only)			
22	Balance due HHA/Program (Line 20, Plus Line 20.01, minus line 21) (Indicate overpayments in brackets)			22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			23

ANALYSIS OF PAYMENTS TO PROVIDER - BASED H H A's FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: _____ HHA NO.: _____	PERIOD: FROM _____ TO _____	WORKSHEET H-7

	Description			PART A Mo/Day/Yr 1	PART A Amount 2	PART B Mo/Day/Yr 3	PART B Amount 4	
1	Total interim payments paid to provider							1
2	Interim pymts 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)	Program to Provider	.01					3.01
			.02					3.02
			.03					3.03
			.04					3.04
			.05					3.05
		Provider to Program	.50					3.50
			.51					3.51
			.52					3.52
			.53					3.53
			.54					3.54
	SUBTOTAL (Sum of lines 3.01-3.05, minus sum of lines 3.50-3.54)		.99					3.99
4	TOTAL INTERIM PAYMENTS (Sum of lines 1, 2 and 3.99) (Transfer to Workseet H-6, Part II, column as appropriate, line 21)							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 5.01-5.03 minus sum of lines 5.50-5.52)		.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	.50					6.50
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 provic agrees to the amount of repayment, even though total repayment is not accomplished until a later da