

ANALYSIS OF PROVIDER - BASED HOME HEALTH AGENCY COSTS						PROVIDER CCN: HHA <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET H		
COST CENTER DESCRIPTIONS	SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION (see instructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	TOTAL (sum of cols. 1 thru 5)	RECLASSIFICATIONS	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
15 Telemedicine										15
HHA NONREIMBURSABLE SERVICES										
16 Home Dialysis Aide Services										16
17 Respiratory Therapy										17
18 Private Duty Nursing										18
19 Clinic										19
20 Health Promotion Activities										20
21 Day Care Program										21
22 Home Delivered Meals Program										22
23 Homemaker Service										23
24 All Others										24
25 Total (sum of lines 1-24)										25

Column, 6 line 25 should agree with the Worksheet A, column 3, line 70, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

PROVIDER 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 through 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								12
13	Drugs								13
14	DME								14
15	Telemedicine								15
HHA NONREIMBURSABLE SERVICES									
16	Home Dialysis Aide Services								16
17	Respiratory Therapy								17
18	Private Duty Nursing								18
19	Clinic								19
20	Health Promotion Activities								20
21	Day Care Program								21
22	Home Delivered Meals Program								22
23	Homemaker Service								23
24	All Others								24
25	Total (sum of lines 1-24)								25

COST ALLOCATION - HHA STATISTICAL BASIS					PROVIDER CCN:	PERIOD :	WORKSHEET H-1,		
					HHA CCN :	FROM _____	PART II		
						TO _____			
	NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE (Square Feet)	TRANS- PORTATION (Mileage)	RECONCIL- IATION	ADMINIS- TRATIVE & GENERAL (Accumulated Cost)	TOTAL	
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						0
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								12
13	Drugs								13
14	DME								14
15	Telemedicine								15
HHA NONREIMBURSABLE SERVICES									
16	Home Dialysis Aide Services								16
17	Respiratory Therapy								17
18	Private Duty Nursing								18
19	Clinic								19
20	Health Promotion Activities								20
21	Day Care Program								21
22	Home Delivered Meals Program								22
23	Homemaker Service								23
24	All Others								24
25	Total (sum of lines 1-24)								25
26	Cost to be allocated								26
27	Unit Cost Multiplier								27

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

PROVIDER CCN:

HHA *CCN*:

PERIOD:
FROM _____
TO _____

WORKSHEET H-2,
PART I

	From Wkst. H-1, Pt. I, col. 6, line	HHA TRIAL BALANCE (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	SUBTOTAL (cols. 0 through 3)	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT						
HHA COST CENTER		0	1	2	3	3A	4	5	6	
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 Telemedicine	15									11
12 Home Dialysis Aide Services	16									12
13 Respiratory Therapy	17									13
14 Private Duty Nursing	18									14
15 Clinic	19									15
16 Health Promotion Activities	20									16
17 Day Care Program	21									17
18 Home Delivered Meals Program	22									18
19 Homemaker Service	23									19
20 All Others	24									20
21 Totals (sum of lines 1-20) (2)										21
22 Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.										22

- (1) Column 0, line 21 must agree with Wkst. A, col. 7, line 70.
- (2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		PROVIDER CCN: HHA <i>CCN</i> :			PERIOD: FROM _____ TO _____		WORKSHEET H-2, PART I		
<i>HHA</i> COST CENTER		HOUSE KEEPING 7	DIETARY 8	NURSING ADMINIS- TRATION 9	CENTRAL SERVICES & SUPPLY 10	PHARMACY 11	MEDICAL RECORDS & LIBRARY 12	SOCIAL SERVICE 13	
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS				PROVIDER CCN: HHA <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET H-2, PART I			
HHA COST CENTER		NURSING AND ALLIED HEALTH EDUCATION 14	OTHER GENERAL SERVICE 15	SUBTOTAL (sum of cols. 3A through 15) 16	POST STEPDOWN ADJUSTMENTS 17	SUBTOTAL (cols. 16 ± 17) 18	ALLOCATED HHA A&G (see Pt. II) 19	TOTAL HHA COSTS 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
10	DME								10
11	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20) (2)								21
22	Unit Cost Multiplier: column 18, line 1 divided by the sum of column 18, line 21, minus column 18, line 1, rounded to 6 decimal places.								22

(2) Columns 0 through 18, line 21 must agree with the corresponding columns of Wkst. B, Pt. I, line 70.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II	
HHA COST CENTER	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (Gross Salaries)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accumulated Cost)	OPERATION OF PLANT (Square Feet)	LAUNDRY & LINEN SERVICE (Pounds of Laundry)	
	BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value or Square Feet)						
	1	2	3	4A	4	5	6	
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	Telemedicine							11
12	Home Dialysis Aide Services							12
13	Respiratory Therapy							13
14	Private Duty Nursing							14
15	Clinic							15
16	Health Promotion Activities							16
17	Day Care Program							17
18	Home Delivered Meals Program							18
19	Homemaker Service							19
20	All Others							20
21	Totals (sum of lines 1-20)							21
22	Total cost to be allocated							22
23	Unit Cost Multiplier							23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II		
HHA COST CENTER			HOUSE-KEEPING (Hours of Service)	DIETARY (Meals Served)	NURSING ADMINIS-TRATION (Direct Nurs. Hrs.)	CENTRAL SERVICES & SUPPLY (Costed Requis.)	PHARMACY (Costed Requis.)	MEDICAL RECORDS & LIBRARY (Time Spent)	SOCIAL SERVICE (Time Spent)
			7	8	9	10	11	12	13
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	Telemedicine								11
12	Home Dialysis Aide Services								12
13	Respiratory Therapy								13
14	Private Duty Nursing								14
15	Clinic								15
16	Health Promotion Activities								16
17	Day Care Program								17
18	Home Delivered Meals Program								18
19	Homemaker Service								19
20	All Others								20
21	Totals (sum of lines 1-20)								21
22	Total cost to be allocated								22
23	Unit Cost Multiplier								23

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS			PROVIDER CCN: HHA <i>CCN</i> :		PERIOD : FROM _____ TO _____		WORKSHEET H-2, PART II	
HHA COST CENTER	NURSING AND ALLIED HEALTH EDUCATION (Assigned Time) 14	OTHER GENERAL SERVICE (SPECIFY) 15	SUBTOTAL (sum of cols. 3A through 15) 16	POST STEPDOWN ADJUSTMENTS 17	SUBTOTAL (cols. 16 ± 17) 18	ALLOCATED HHA A&G (see Pt. II) 19	TOTAL HHA COSTS 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
10	DME							10
11	Telemedicine							11
12	Home Dialysis Aide Services							12
13	Respiratory Therapy							13
14	Private Duty Nursing							14
15	Clinic							15
16	Health Promotion Activities							16
17	Day Care Program							17
18	Home Delivered Meals Program							18
19	Homemaker Service							19
20	All Others							20
21	Totals (sum of lines 1-20)							21
22	Total cost to be allocated							22
23	Unit Cost Multiplier							23

APPORTIONMENT OF PATIENT SERVICE COSTS	PROVIDER CCN: HHA CCN:	PERIOD : FROM _____ TO _____	WORKSHEET H-3, Parts I & II
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Check applicable box: Title V Title XVIII Title XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

Cost Per Visit Computation	From, Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Costs (col. 1 + col. 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 A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
Patient Services														
	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

Patient Services by CBSA						CBSA No. (1)	Program Visits				
							Part A	Part B			
								Not Subject to Deductibles & Coinsurance	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	From Wkst. H-2, Pt. I, col. 20, line -	Facility Costs (from Wkst. H-2, Pt. I)	Shared Ancillary Costs (from Pt. II)	Total HHA Cost (cols. 1 + 2)	Total Charges (from HHA records)	Ratio (col. 3 ÷ col. 4)	Program Covered Charges			Cost of Services				
							Part A	Part B		Part A	Part B			
								Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
Other Patient Services														
	8	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 SKILLED NURSING FACILITY DEPARTMENTS

	From Wkst. C, col. 3, line -	Cost to Charge Ratio	Total HHA Charges (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Pt. 1 -
		1	2	3	4
1 Physical Therapy	44				col. 2, line 2
2 Occupational Therapy	45				col. 2, line 3
3 Speech Pathology	46				col. 2, line 4
4 Cost of Medical Supplies	48				col. 2, line 15
5 Cost of Drugs	49				col. 2, line 16

(1) The CBSA numbers flow from Wkst. S-4, line 22, and subscripts as indicated should be replicated on lines 8-13.

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT	PROVIDER CCN:	PERIOD :	WORKSHEET H-4, Parts I & II
	HHA <i>CCN</i> :	FROM _____ TO _____	

Check applicable box: Title V Title XVIII Title XIX

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

Description	Part A 1	Part B		
		Not Subject to Deductibles & Coinsurance 2	Subject to Deductibles & Coinsurance 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 through 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
30.99 Sequestration amount (see instructions)			30.99
31 Subtotal (line 29 plus/minus line 30)			31
32 Interim payments (see instructions)			32
33 Tentative settlement (for contractor use only)			33
34 Balance due provider/program (see instructions)			34
35 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			35

ANALYSIS OF PAYMENTS TO PROVIDER - BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: HHA <i>CCN</i> :	PERIOD : FROM _____ TO _____	WORKSHEET H-5
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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/contractor for services rendered in the cost reporting period. If none, enter 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	.02			3.01
		.03			3.02
		.04			3.03
		.05			3.04
		.50			3.05
	Provider to Program	.51			3.50
		.52			3.51
		.53			3.52
		.54			3.53
		.99			3.54
SUBTOTAL (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)					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 CONTRACTOR					
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)					5.99
6 Determine net settlement amount (balance due) based on the cost report (1)	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				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.