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 overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0022
EXPIRES: (insert expiration date)

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically prepared cost report	Date:	Time:
	2. [ ] Manually prepared cost report (limited to low or no utilization)		
	3. [ ] If this is an amended cost report enter the number of times the provider resubmitted this cost report.		
	4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.		

Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received:_____ 7. Contractor No.:_____ 8. [ ] Initial Report for this HHA CCN 9. [ ] Final Report for this HHA CCN	10. NPR Date:_____ 11. Contractors Vendor Code: _____ 12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION

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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)}for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and 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.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial Officer or Administrator of Provider (s)

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII	
		1	
1	HOME HEALTH AGENCY		1

The above amount represents "due to" or "due from" the Medicare program

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 195 hours per reponse, 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 Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

IDENTIFICATION DATA	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2, PART I

HOME HEALTH AGENCY COMPLEX ADDRESS

1	Street:	P.O. Box:		1
2	City:	State:	ZIP Code:	2

HOME HEALTH AGENCY COMPONENT IDENTIFICATION

	Component	Component Name	Provider CCN	Date Certified	
	0	1	2	3	
3	Home Health Agency				3
4	HHA-based Hospice				4
5	Cost Reporting Period (mm/dd/yyyy)	From:	To:		5

6	Type of control (see instructions)		6
7	Does the HHA qualify as a nominal charge provider (see 42 CFR 409.3)?		7
8	Does the HHA contract with outside suppliers for physical therapy services?		8
9	Does the HHA contract with outside suppliers for occupational therapy services?		9
10	Does the HHA contract with outside suppliers for speech therapy services?		10
11	Are there any costs included in Worksheet A that resulted from transactions with related organizations or home office costs as defined in CMS Pub. 15-1, chapter 10? If yes, complete Worksheet A-8-1.		11

MALPRACTICE INSURANCE INFORMATION

12	Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				12
13	If line 12 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				13
		Premiums	Paid Losses	Self-Insurance	
		1	2	3	
14	List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.				14
15	Are malpractice premiums and paid losses reported in a cost center other than A&G? If yes, submit supporting schedule listing cost centers and amounts contained therein.				15

HOME OFFICE INFORMATION				1	2	
16	Does this HHA receive an allocation of costs from more than one home office? (see instructions)					16
17	Is this HHA part of a home office or chain organization? Enter in column 1, "Y" for yes or "N" for no. If column 1 is yes, and home office costs are claimed, enter in column 2 the home office chain number and complete lines 18 through 20.					17
18	Home Office Name:		Contractor Name:	Contractor No. :		18
19	Street:	P.O. Box:				19
20	City:	State:	ZIP Code:			20

REIMBURSEMENT DATA	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2, PART II

PROVIDER ORGANIZATION AND OPERATION

		Y/N	Date	V/I	
		1	2	3	
1	Has the HHA changed ownership? (see instructions) Enter "Y" for yes or "N" for no in column 1. If yes, enter the date of the change in column 2. (mm/dd/yyyy) (see instructions)				1
2	Has the HHA terminated participation in the Medicare program? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the termination date, and enter in column 3, "V" for voluntary or "I" for involuntary.				2
3	Is the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? Enter "Y" for yes or "N" for no in column 1. (see instructions)				3

FINANCIAL DATA AND REPORTS

		Y/N	A / C / R	Date	
		1	2	3	
4	Column 1: Were the financial statements prepared by a certified public accountant? Enter "Y" for yes or "N" for no. Column 2: If yes, enter: "A" for audited, "C" for compiled, or "R" for reviewed. Submit complete copy of financial statements or enter date available in column 3. (mm/dd/yyyy)				4
5	Are the cost report total expenses and total revenues different from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 1. If yes, submit reconciliation.				5

BAD DEBT

		Y/N	
6	Is the HHA or HHA-based entities seeking reimbursement for bad debts? If yes, see instructions.		6
7	If line 6 is yes, did the HHA's bad debt collection policy change during this cost reporting period? If yes, submit copy.		7
8	If line 6 is yes, were patient coinsurance amounts waived? If yes, see instructions.		8

PS&R REPORT DATA

		Y/N	Date	
		1	2	
9	Was the cost report prepared using the PS&R report only? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date of the PS&R report used to prepare the cost report. (mm/dd/yyyy) (see instructions.)			9
10	Was the cost report prepared using the PS&R report for totals and the provider's records for allocation? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the paid-through date of the PS&R report. (mm/dd/yyyy) (see instructions)			10
11	If line 9 or 10 is yes, were adjustments made to PS&R report data for additional claims that have been billed but are not included on the PS&R report used to file the cost report? Enter "Y" for yes or "N" for no. If yes, see instructions.			11
12	If line 9 or 10 is yes, were adjustments made to PS&R report data for corrections of other PS&R report information? Enter "Y" for yes or "N" for no. If yes, see instructions.			12
13	If line 9 or 10 is yes, were adjustments made to PS&R Report data for Other? If yes, describe the other adjustments: _____			13
14	Was the cost report prepared only using the HHA's records? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

COST REPORT PREPARER CONTACT INFORMATION

15	First name:	Last name:	Title:	15
16	Employer:			16
17	Phone number:	Email address:		17

STATISTICAL DATA	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PARTS I, II, & III

PART I - VISITS DATA

	DESCRIPTION	Title XVIII - Medicare		Title XIX - Medicaid		Other		Total		
		Visits	Patient Census	Visits	Patient Census	Visits	Patient Census	Visits	Patient Census	
		1	2	3	4	5	6	7	8	
1	Skilled Nursing Care - Registered Nurse									1
2	Skilled Nursing Care - Licensed Practical Nurse									2
3	Physical Therapy									3
4	Physical Therapy Assistant									4
5	Occupational Therapy									5
6	Certified Occupational Therapy Assistant									6
7	Speech-Language Pathology									7
8	Medical Social Service									8
9	Home Health Aide									9
10	All Other Services									10
11	Total Visits									11
12	Home Health Aide Hours									12
13	Unduplicated Census Count									13

PART II - EMPLOYMENT DATA (FULL TIME EQUIVALENT)

14	Number of hours in your normal work week		14

		Staff	Contract	Total	
		1	2	3	
15	Administrator and Assistant Administrator(s)				15
16	Director and Assistant Director(s)				16
17	Other Administrative Personnel				17
18	Nursing Supervisor				18
19	Registered Nurses				19
20	Licensed Practical Nurses				20
21	Certified Nursing Assistants				21
22	Physical Therapy Supervisor				22
23	Physical Therapists				23
24	Physical Therapy Assistants				24
25	Occupational Therapy Supervisor				25
26	Occupational Therapists				26
27	Occupational Therapy Assistants				27
28	Speech-Language Pathology Supervisor				28
29	Speech-Language Pathologists				29
30	Medical Social Services Supervisor				30
31	Medical Social Services				31
32	Home Health Aide Supervisor				32
33	Home Health Aides				33
34					34

PART III - CORE BASED STATISTICAL AREA DATA

		1	
35	Enter the total number of CBSAs where Medicare covered services were provided during the cost reporting period.		35
		CBSA Codes	
36	List all CBSA codes for areas where Medicare covered home health services were provided. (see instructions)		36

STATISTICAL DATA	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART IV

PART IV - PPS ACTIVITY DATA

	DESCRIPTION	Full Episodes/ Periods without Outliers	Full Episodes/ Periods with Outliers	LUPA Episodes/ Periods	PEP Episodes/ Periods	Total Episodes/ Periods	
		1	2	3	4	5	
1	Skilled Nursing Care Visits						1
2	Skilled Nursing Care Charges						2
3	Physical Therapy Visits						3
4	Physical Therapy Charges						4
5	Occupational Therapy Visits						5
6	Occupational Therapy Charges						6
7	Speech-Language Pathology Visits						7
8	Speech-Language Pathology Charges						8
9	Medical Social Service Visits						9
10	Medical Social Service Charges						10
11	Home Health Aide Visits						11
12	Home Health Aide Charges						12
13	Total Visits (sum of lines 1, 3, 5, 7, 9, and 11)						13
14	Other Charges						14
15	Total Charges (sum of lines 2, 4, 6, 8, 10, 12, and 14)						15
16	Total Number of Episodes/Periods						16
17	Total Number of Outlier Episodes/Periods						17
18	Total Non-Routine Medical Supply Charges						18

STATISTICAL DATA DIRECT CARE EXPENDITURES	HHA CCN: _____		PERIOD : FROM: _____ TO: _____		WORKSHEET S-3 PART V	
	Amount Reported	Fringe Benefits	Adjusted Salaries (col. 1 + col. 2)	Paid Hours Related to Salary in col. 3	Average Hourly Wage (col. 3 ÷ col. 4)	
OCCUPATIONAL CATEGORY	1	2	3	4	5	
Direct Salaries						
Nursing Occupations						
1 Nursing Supervisor						1
2 Registered Nurses						2
3 Licensed Practical Nurses						3
4 Certified Nursing Assistants						4
5 Total Nursing (sum of lines 1 through 4)						5
6 Physical Therapy Supervisor						6
7 Physical Therapists						7
8 Physical Therapy Assistants						8
9 Occupational Therapy Supervisor						9
10 Occupational Therapists						10
11 Occupational Therapy Assistants						11
12 Speech-Language Pathology Supervisor						12
13 Speech-Language Pathologists						13
14 Other Medical Staff						14
Contract Labor						
Nursing Occupations						
15 Nursing Supervisor						15
16 Registered Nurses						16
17 Licensed Practical Nurses						17
18 Certified Nursing Assistants						18
19 Total Nursing (sum of lines 15 through 18)						19
20 Physical Therapy Supervisor						20
21 Physical Therapists						21
22 Physical Therapy Assistants						22
23 Occupational Therapy Supervisor						23
24 Occupational Therapists						24
25 Occupational Therapy Assistants						25
26 Speech-Language Pathology Supervisor						26
27 Speech-Language Pathologists						27
28 Other Medical Staff						28

HHA-BASED HOSPICE STATISTICAL DATA	HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-4 PARTS I & II

PART I - ENROLLMENT DAYS

		Unduplicated Days				
		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1	2	3	4	
1	Hospice Continuous Home Care					1
2	Hospice Routine Home Care					2
3	Hospice Inpatient Respite Care					3
4	Hospice General Inpatient Care					4
5	Total Hospice Days					5

PART II- CONTRACTED STATISTICAL DATA

		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1	2	3	4	
6	Hospice Inpatient Respite Care					6
7	Hospice General Inpatient Care					7

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | HHA CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A

			SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION	CONTRACTED PURCHASED SERVICES	OTHER COSTS	TOTAL	RECLASSIFICATION	RECLASSIFIED TRIAL BALANCE (col. 6 + 7)	ADJUSTMENTS	EXPENSES FOR COST ALLOCATION (col. 8 + 9)	
			1	2	3	4	5	6	7	8	9	10	
		GENERAL SERVICE COST CENTERS											
1	0100	Capital Related - Buildings & Fixtures											1
2	0200	Capital Related - Movable Equipment											2
3	0300	Plant Operation & Maintenance											3
4	0400	Transportation (see instructions)											4
5	0500	Remote Patient Monitoring											5
6	0600	Administrative and General											6
7	0700	Nursing Administration											7
8	0800	Medical Records											8
9	0900												9
		HHA REIMBURSABLE SERVICES											
16	1600	Skilled Nursing Care - Registered Nurse											16
17	1700	Skilled Nursing Care - Licensed Practical Nurse											17
18	1800	Physical Therapy											18
19	1900	Physical Therapy Assistant											19
20	2000	Occupational Therapy											20
21	2100	Certified Occupational Therapy Assistant											21
22	2200	Speech-Language Pathology											22
23	2300	Medical Social Services											23
24	2400	Home Health Aide											24
25	2500	Medical Supplies (see instructions)											25
26	2600	Drugs											26
27	2700	Cost of Administering Vaccines											27
28	2800	Durable Medical Equipment/Oxygen											28
29	2900	Disposable Devices											29
30	3000												30
		HHA NONREIMBURSABLE SERVICES											
39	3900	Home Dialysis Aide Services											39
40	4000	Respiratory Therapy											40
41	4100	Private Duty Nursing											41
42	4200	Clinic											42
43	4300	Health Promotion Activities											43
44	4400	Day Care Program											44
45	4500	Home Delivered Meals Program											45
46	4600	Homemaker Services											46
47	4700	Telehealth											47
48	4800	Advertising											48
49	4900	Fundraising											49
50	5000												50
		SPECIAL PURPOSE COST CENTERS											
57	5700	Hospice											57
58	5800												58
100		Total											100

RECLASSIFICATIONS | HHA CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASE				DECREASE				
			COST CENTER	LINE NO.	SALARY	OTHER	COST CENTER	LINE NO.	SALARY	OTHER	
		1	2	3	4	5	6	7	8	9	
1											1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
100	TOTAL RECLASSIFICATIONS (Sum of columns 4 and 5 must equal sum of columns 8 and 9) (2)										100

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 7, lines as appropriate.

ADJUSTMENTS TO EXPENSES	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8

	Description (1)	BASIS / CODE (2)	Amount	Expense Classification on Worksheet A To/From Which The Amount is to be Adjusted		
				Cost Center	Line No.	
		1	2	3	4	
1	Excess funds generated from operations, other than net income					1
2	Trade, quantity, time and other discounts on purchases (chapter 8)					2
3	Rebates and refunds of expenses (chapter 8)					3
4	Related organization transactions (chapter 10)	Worksheet A-8-1				4
5	Sale of medical records and abstracts					5
6	Income from imposition of interest, finance or penalty charges					6
7	Sale of medical and surgical supplies to other than patients					7
8	Sale of Drugs to other than patients					8
9	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments					9
10	Lobbying Activities (chapter 21)					10
11	Advertising costs (chapter 21)					11
12	(3)					12
50	TOTAL (sum of lines 1 through 49)					50

(1) Description - All line references in this column pertain to the CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - If cost cannot be determined

(3) Additional adjustments may be made on lines 12 thru 49 and subscripts thereof (see instructions)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-1

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, column 8	Net Adjustments (col. 4 minus col. 5) *	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer col. 6, line 5 to Worksheet A-8, column 2, line 4.						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 9, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 through 5, the amount allowable should be indicated in column 4 of this section.

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATIONS AND/OR HOME OFFICE

The Secretary, by virtue of authority granted under section 1814(b)(1) of the Social Security Act, requires the HHA to furnish the information requested on Part II of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under Title XVIII.

			Related Organization(s) and/or Home Office				
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in HHA.
B. Corporation, partnership or other organization has financial interest in HHA.
C. HHA has financial interest in corporation, partnership or other organization.
D. Director, officer, administrator or key person of HHA or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator or key person of HHA and related organization.
F. Director, officer, administrator or key person of related organization or relative of such person has financial interest in HHA.
G. Other (financial or non-financial) specify _____.

COST ALLOCATION
ALLOCATION OF GENERAL SERVICE COSTS

HHA CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET B

		NET EXPENSES FOR COST ALLOCATION (from Wkst. A, col. 10)	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION	REMOTE PATIENT MONITORING	SUBTOTAL (cols. 0-5)	ADMINISTRA-TIVE & GENERAL	NURSING ADMINISTRA-TION	MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
			BLDGS & & FIXTURES	MOVABLE EQUIPMENT										
		0	1	2	3	4	5	5A	6	7	8	9	10	
	GENERAL SERVICE COST CENTERS													
1	Capital Related - Buildings and Fixtures													1
2	Capital Related - Movable Equipment													2
3	Plant Operation & Maintenance													3
4	Transportation (see instructions)													4
5	Remote Patient Monitoring													5
6	Administrative and General													6
7	Nursing Administration													7
8	Medical Records													8
9	Other General Service													9
	HHA REIMBURSABLE SERVICES													
16	Skilled Nursing Care - Registered Nurse													16
17	Skilled Nursing Care - Licensed Practical Nurse													17
18	Physical Therapy													18
19	Physical Therapy Assistant													19
20	Occupational Therapy													20
21	Certified Occupational Therapy Assistant													21
22	Speech-Language Pathology													22
23	Medical Social Services													23
24	Home Health Aide													24
25	Medical Supplies (see instructions)													25
26	Drugs													26
27	Cost of Administering Vaccines													27
28	Durable Medical Equipment/Oxygen													28
29	Disposable Devices													29
30														30
	HHA NONREIMBURSABLE SERVICES													
39	Home Dialysis Aide Services													39
40	Respiratory Therapy													40
41	Private Duty Nursing													41
42	Clinic													42
43	Health Promotion Activities													43
44	Day Care Program													44
45	Home Delivered Meals Program													45
46	Homemaker Services													46
47	Telehealth													47
48	Advertising													48
49	Fundraising													49
50														50
	SPECIAL PURPOSE COST CENTER													
57	Hospice													57
58														58
100	Total													100

COST ALLOCATION
STATISTICAL BASES

HHA CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET B-1

	COST CENTER	CAPITAL RELATED COSTS		PLANT OPERATION MAINTENANCE	TRANS-PORTATION	REMOTE PATIENT MONITORING	RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL	NURSING ADMINISTRA-TION	MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
		BLDGS & & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)	(SQUARE FEET)	(MILEAGE)	(TIME SPENT)		(ACCUM. COST)	(DIRECT NURS HRS)	(TIME SPENT)	(SPECIFY)		
		1	2	3	4	5	6A	6	7	8	9	10	
	GENERAL SERVICE COST CENTER												
1	Capital Related - Buildings and Fixtures												1
2	Capital Related - Movable Equipment												2
3	Plant Operation & Maintenance												3
4	Transportation (see instructions)												4
5	Remote Patient Monitoring												5
6	Administrative and General												6
7	Nursing Administration												
8	Medical Records												
9	Other General Service												7
	HHA REIMBURSABLE SERVICES												
16	Skilled Nursing Care - Registered Nurse												16
17	Skilled Nursing Care - Licensed Practical Nurse												17
18	Physical Therapy												18
19	Physical Therapy Assistant												19
20	Occupational Therapy												20
21	Certified Occupational Therapy Assistant												21
22	Speech-Language Pathology												22
23	Medical Social Services												23
24	Home Health Aide												24
25	Medical Supplies (see instructions)												25
26	Drugs												26
27	Cost of Administering Vaccines												27
28	Durable Medical Equipment/Oxygen												28
29	Disposable Devices												29
30													30
	HHA NONREIMBURSABLE SERVICES												
39	Home Dialysis Aide Services												39
40	Respiratory Therapy												40
41	Private Duty Nursing												41
42	Clinic												42
43	Health Promotion Activities												43
44	Day Care Program												44
45	Home Delivered Meals Program												45
46	Homemaker Services												46
47	Telehealth												47
48	Advertising												48
49	Fundraising												49
50													50
	SPECIAL PURPOSE COST CENTER												
57	Hospice												57
58													58
100	Cost To Be Allocated (per wkst B)												100
101	Unit Cost Multiplier												101

APPORTIONMENT OF PATIENT SERVICE COSTS	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET C PARTS I & II

PART I - AGGREGATE HHA COST PER VISIT AND AGGREGATE MEDICARE COST COMPUTATION

	Cost Per Visit Computation Patient Services	From Wkst B, Col. 10, Line:	Total		Average Cost Per Visit (Cols 2 ÷ 3)	HHA Medicare Program Visits	HHA Medicare Program Costs (Col. 4 x Col. 5)	
			Cost	Visits				
		1	2	3	4	5	6	
1	Skilled Nursing Care - Registered Nurse	16						1
2	Skilled Nursing Care - Licensed Practical Nurse	17						2
3	Physical Therapy	18						3
4	Physical Therapy Assistant	19						4
5	Occupational Therapy	20						5
6	Certified Occupational Therapy Assistant	21						6
7	Speech-Language Pathology	22						7
8	Medical Social Services	23						8
9	Home Health Aide Services	24						9
10	Total (sum of lines 1-9)							10

PART II - SUPPLIES, DRUGS, AND DISPOSABLE DEVICES COST COMPUTATION

	Other Patient Services	From Wkst B, Col. 10, Line:	Total Cost	Total Charges (from HHA records or PS&R)	Ratio (Col 1 ÷ 2)	Medicare Covered Charges			Cost of Medicare Services			
						OPPS Reimbursed Services	HHA Services		OPPS Reimbursed Services	HHA Services		
							Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			1	2	3	4	5	6	7	8	9	
11	Cost of Medical Supplies	25										11
12	Cost of Drugs	26										12
13	Disposable Devices	29										13

CALCULATION OF REIMBURSEMENT SETTLEMENT	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET D

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

		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1	2	
1	Reasonable cost of vaccines (see instructions)			1
2	Total vaccines charges			2
3	Aggregate 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(e)			4
5	Ratio of line 3 to 4 (not to exceed 1.000000)			5
6	Total customary charges (multiply line 5 by line 2 for columns 1 and 2) (see instructions)			6
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) (see instructions)			7
8	Excess of reasonable cost over customary charges (see instructions)			8
9	Subtotal of Reasonable Cost (see instructions)			9

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

10	Total PPS payment - full episodes/periods without outliers		10
11	Total PPS payment - full episodes/periods with outliers		11
12	Total PPS payment - LUPA episodes/periods		12
13	Total PPS payment - PEP episodes/periods		13
14	Total PPS outlier payment - full episodes/periods with outliers		14
15	Total PPS outlier payment - PEP episodes/periods		15
16	Total other payments (specify)		16
17	Payment for services reimbursed under OPPS		17
18	DME Payment		18
19	Oxygen Payment		19
20	Prosthetics and Orthotics Payment		20
21	Primary Payer Payments		21
22	Part B deductibles billed to Medicare patients (exclude coinsurance)		22
23	Subtotal (sum of lines 9 through 20 minus lines 21 and 22)		23
24	Excess reasonable cost (see instructions)		24
25	Subtotal (line 23 minus line 24)		25
26	Coinsurance billed to Medicare patients (from your records)		26
27	Allowable bad debts (see instructions)		27
28	Adjusted reimbursable bad debts (see instructions)		28
29	Allowable bad debts for dual eligible beneficiaries (see instructions)		29
30	Subtotal (line 25 minus line 26, plus line 28)		30
31			31
32	Other demonstration payment adjustment amount before sequestration		32
33	Amount due HHA prior to sequestration adjustment (line 30 plus or minus line 31, minus line 32)		33
34	Sequestration adjustment (see instructions)		34
35	Amount due HHA after sequestration adjustment (line 33 minus line 34)		35
36	Other demonstration payment adjustment amount after sequestration		36
37	Amount due HHA (line 35 minus line 36)		37
38	Total interim payments (from Worksheet D-1, line 4)		38
39	Tentative settlement (For contractor use only)		39
40	Balance due HHA/Medicare program (line 37 minus lines 38 and 39) (indicate overpayments in brackets)		40
41	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		41

ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	HHA CCN: _____	PERIOD: FROM: _____ TO : _____	WORKSHEET D-1

	Description			mm/dd/yyyy 1	Amount 2	
1	Total interim payments paid to HHA					1
2	Interim pymts payable on individual bills either submitted or to be submitted to the contractor, 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 3.01-3.49, 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 Worksheet D, Part II, line 38)					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)		.99			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	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5 and 6, where an amount is due HHA to program, show the amount and date on which the HHA agrees to the amount of repayment, even though total repayment is not accomplished until a later date.

BALANCE SHEET	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET F

	ASSETS (Omit Cents)	AMOUNT	
	CURRENT ASSETS		
1	Cash on hand and in banks		1
2	Temporary investments		2
3	Notes receivable		3
4	Accounts receivable		4
5	Other receivables		5
6	Less: allowances for uncollectible notes and accounts receivable		6
7	Inventory		7
8	Prepaid expenses		8
9	Other current assets		9
10	TOTAL CURRENT ASSETS (sum of lines 1 through 9)		10
	FIXED ASSETS		
11	Land		11
12	Land Improvements		12
13	Less: accumulated depreciation		13
14	Buildings		14
15	Less: accumulated depreciation		15
16	Leasehold improvements		16
17	Less: accumulated depreciation		17
18	Fixed equipment		18
19	Less: accumulated depreciation		19
20	Automobiles and trucks		20
21	Less: Accumulated Depreciation		21
22	Major movable equipment		22
23	Less: accumulated depreciation		23
24	Minor equipment		24
25	Less: Accumulated depreciation		25
26	Minor equipment nondepreciable		26
27	TOTAL FIXED ASSETS (sum of lines 11 through 26)		27
	OTHER ASSETS		
28	Investments		28
29	Deposits on leases		29
30	Due from owners/officers		30
31	TOTAL OTHER ASSETS (sum of lines 28 through 30)		31
32	TOTAL ASSETS (sum of lines 10, 27 and 31)		32

	LIABILITIES AND FUND BALANCE (Omit Cents)		
	CURRENT LIABILITIES		
33	Accounts payable		33
34	Salaries, wages & fees payable		34
35	Payroll taxes payable		35
36	Notes and payable loans (short term)		36
37	Deferred income		37
38	Accelerated payments		38
39	Other current liabilities		39
40	TOTAL CURRENT LIABILITIES (sum of lines 33 through 39)		40
	LONG TERM LIABILITIES		
41	Mortgage payable		41
42	Notes payable		42
43	Unsecured loans		43
44	Other long term liabilities		44
45	TOTAL LONG TERM LIABILITIES (sum of lines 41 through 44)		45
46	TOTAL LIABILITIES (sum of lines 40 and 45)		46
	CAPITAL ACCOUNTS		
47	FUND BALANCES		47
48	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 46 and 47)		48

STATEMENT OF REVENUES AND EXPENSES		HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET F-1	

		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1	2	3	4	
1	Gross patient revenues					1
2	Less: Allowances and discounts on patients' accounts					2
3	Net patient revenues (line 1 minus line 2)					3
				1	2	
4	Operating expenses (From Worksheet A, column 6, line 100)					4
5						5
6						6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17	Less total operating expenses (sum of lines 4 through 16)					17
18	Net income from service to patients (line 3 minus line 17)					18
	Other income:					
19	Contributions, donations, bequests, etc.					19
20	Income from investments					20
21	Purchase discounts					21
22	Rebates and refunds of expenses					22
23	Sale of Medical and Nursing Supplies to other than patients					23
24	Sale of durable medical equipment to other than patients					24
25	Sale of drugs to other than patients					25
26	Sale of medical records and abstracts					26
27	Government Appropriations					27
28						28
29						29
30						30
31						31
32	Total Other Income (sum of lines 19 through 31)					32
33	Net Income or Loss for the period (line 18 plus line 32)					33

ANALYSIS OF HHA-BASED HOSPICE COSTS

HHA CCN:

HOSPICE CCN:

PERIOD:
FROM:
TO: _____

WORKSHEET O

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS									
1	Cap Rel Costs-Bldg & Fixt*								1
2	Cap Rel Costs-Mvble Equip*								2
3	Employee Benefits Department*								3
4	Administrative & General *								4
5	Plant Operation & Maintenance*								5
6	Laundry & Linen Service*								6
7	Housekeeping*								7
8	Dietary*								8
9	Nursing Administration*								9
10	Routine Medical Supplies*								10
11	Medical Records*								11
12	Staff Transportation*								12
13	Volunteer Service Coordination*								13
14	Pharmacy*								14
15	Physician Administrative Services*								15
16	Other General Service*								16
17	Patient/Residential Care Services								17
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care-Contracted**								25
26	Physician Services**								26
27	Nurse Practitioner**								27
28	Registered Nurse**								28
29	LPN/LVN**								29
30	Physical Therapy**								30
31	Occupational Therapy**								31
32	Speech-Language Pathology**								32
33	Medical Social Services**								33
34	Spiritual Counseling**								34
35	Dietary Counseling**								35
36	Counseling - Other**								36
37	Hospice Aide & Homemaker Services**								37
38	Durable Medical Equipment/Oxygen**								38
39	Patient Transportation**								39

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.
** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

ANALYSIS OF HHA-BASED HOSPICE COSTS

HHA CCN:

HOSPICE CCN:

PERIOD:
FROM:
TO: _____

WORKSHEET O

		SALARIES	OTHER	TOTAL (col. 1 through col. 5)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS (Cont.)									
40	Imaging Services**								40
41	Labs & Diagnostics**								41
42	Medical Supplies-Non-routine**								42
43	Drugs Charged to Patients**								43
44	Outpatient Services**								44
45	Palliative Radiation Therapy**								45
46	Palliative Chemotherapy**								46
47	**								47
NONREIMBURSABLE COST CENTERS									
60	Bereavement Program *								60
61	Volunteer Program *								61
62	Fundraising*								62
63	Hospice/Palliative Medicine Fellows*								63
64	Palliative Care Program*								64
65	Other Physician Services*								65
66	Residential Care *								66
67	Advertising*								67
68	Telehealth/Telemonitoring*								68
69	Thrift Store*								69
70	Nursing Facility Room & Board*								70
71	*								71
100	Total								100

* Transfer the amounts in column 7 to Wkst. O-5, col. 1, line as appropriate.
** See instructions. Do not transfer the amounts in col. 7 to Wkst. O-5.

ANALYSIS OF HHA-BASED HOSPICE COSTS CONTINUOUS HOME CARE	HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-1

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech-Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Drugs Charged to Patients								43
44	Outpatient Services								44
45	Palliative Radiation Therapy								45
46	Palliative Chemotherapy								46
47									47
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 50.

ANALYSIS OF HHA-BASED HOSPICE COST
ROUTINE HOME CARE

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-2

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
DIRECT PATIENT CARE SERVICE COST CENTERS									
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech-Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Drugs Charged to Patients								43
44	Outpatient Services								44
45	Palliative Radiation Therapy								45
46	Palliative Chemotherapy								46
47									47
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 51

ANALYSIS OF HHA-BASED HOSPICE COSTS INPATIENT RESPITE CARE	HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-3

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech-Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Drugs Charged to Patients								43
44	Outpatient Services								44
45	Palliative Radiation Therapy								45
46	Palliative Chemotherapy								46
47									47
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 52

ANALYSIS OF HHA-BASED HOSPICE COSTS GENERAL INPATIENT CARE	HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-4

		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSI-FICATIONS	SUBTOTAL (col. 3 ± col. 4)	ADJUST-MENTS	TOTAL (col. 5 ± col. 6)	
		1	2	3	4	5	6	7	
	DIRECT PATIENT CARE SERVICE COST CENTERS								
25	Inpatient Care - Contracted								25
26	Physician Services								26
27	Nurse Practitioner								27
28	Registered Nurse								28
29	LPN/LVN								29
30	Physical Therapy								30
31	Occupational Therapy								31
32	Speech-Language Pathology								32
33	Medical Social Services								33
34	Spiritual Counseling								34
35	Dietary Counseling								35
36	Counseling - Other								36
37	Hospice Aide and Homemaker Services								37
38	Durable Medical Equipment/Oxygen								38
39	Patient Transportation								39
40	Imaging Services								40
41	Labs and Diagnostics								41
42	Medical Supplies-Non-routine								42
43	Drugs Charged to Patients								43
44	Outpatient Services								44
45	Palliative Radiation Therapy								45
46	Palliative Chemotherapy								46
47									47
100	Total *								100

* Transfer the amount in column 7 to Wkst. O-5, column 1, line 53

DETERMINATION OF HHA-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION	HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-5	
Descriptions	HOSPICE DIRECT EXPENSES (see instructions) 1	GENERAL SERVICE EXPENSES FROM WKST B (see instructions) 2	TOTAL EXPENSES (sum of cols. 1 + 2) 3	
GENERAL SERVICE COST CENTERS				
1 Cap Rel Costs-Bldg & Fixt				1
2 Cap Rel Costs-Mvble Equip				2
3 Employee Benefits Department				3
4 Administrative & General				4
5 Plant Operation & Maintenance				5
6 Laundry & Linen Service				6
7 Housekeeping				7
8 Dietary				8
9 Nursing Administration				9
10 Routine Medical Supplies				10
11 Medical Records				11
12 Staff Transportation				12
13 Volunteer Service Coordination				13
14 Pharmacy				14
15 Physician Administrative Services				15
16 Other General Service				16
17 Patient/Residential Care Services				17
LEVEL OF CARE				
50 Hospice Continuous Home Care				50
51 Hospice Routine Home Care				51
52 Hospice Inpatient Respite Care				52
53 Hospice General Inpatient Care				53
NONREIMBURSABLE COST CENTERS				
60 Bereavement Program				60
61 Volunteer Program				61
62 Fundraising				62
63 Hospice/Palliative Medicine Fellows				63
64 Palliative Care Program				64
65 Other Physician Services				65
66 Residential Care				66
67 Advertising				67
68 Telehealth/Telemonitoring				68
69 Thrift Store				69
70 Nursing Facility Room & Board				70
71				71
99 Negative Cost Center				99
100 Total				100

COST ALLOCATION - HHA-BASED HOSPICE
ALLOCATION OF HHA-BASED HOSPICE GENERAL SERVICE COSTS

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-6
PART I

		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDRY & LINEN	HOUSE-KEEPING	DIETARY	
		0	1	2	3	3A	4	5	6	7	8	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
	NONREIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71												71
99	Negative Cost Center											99
100	Total											100

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-6
PART I

	Descriptions	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMINISTRA-TIVE SVCS	OTHER GENERAL SERVICE	PATIENT / RESIDENTIAL CARE SVCS	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
	NONREIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71												71
99	Negative Cost Center											99
100	Total											100

COST ALLOCATION - HHA-BASED HOSPICE
STATISTICAL BASES

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-6
PART II

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL-IATION	ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	PLANT OP & MAINT (SQUARE FEET)	LAUNDRY & LINEN (IN-FACIL-ITY DAYS)	HOUSE-KEEPING (SQUARE FEET)	DIETARY (IN-FACIL-ITY DAYS)	
		1	2	3	4A	4	5	6	7	8	
	GENERAL SERVICE COST CENTERS										
1	Cap Rel Costs-Bldg & Fixt										1
2	Cap Rel Costs-Mvble Equip										2
3	Employee Benefits Department										3
4	Administrative & General										4
5	Plant Operation & Maintenance										5
6	Laundry & Linen Service										6
7	Housekeeping										7
8	Dietary										8
9	Nursing Administration										9
10	Routine Medical Supplies										10
11	Medical Records										11
12	Staff Transportation										12
13	Volunteer Service Coordination										13
14	Pharmacy										14
15	Physician Administrative Services										15
16	Other General Service										16
17	Patient/Residential Care Services										17
	LEVEL OF CARE										
50	Hospice Continuous Home Care										50
51	Hospice Routine Home Care										51
52	Hospice Inpatient Respite Care										52
53	Hospice General Inpatient Care										53
	NONREIMBURSABLE COST CENTERS										
60	Bereavement Program										60
61	Volunteer Program										61
62	Fundraising										62
63	Hospice/Palliative Medicine Fellows										63
64	Palliative Care Program										64
65	Other Physician Services										65
66	Residential Care										66
67	Advertising										67
68	Telehealth/Telemonitoring										68
69	Thrift Store										69
70	Nursing Facility Room & Board										70
71											71
99	Negative Cost Center										99
101	Cost to be allocated (per Wkst. O-6, Part I)										101
102	Unit cost multiplier										102

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS STATISTICAL BASIS

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM _____
TO _____

WORKSHEET O-6
PART II

	Cost Center Descriptions	NURSING ADMINIS-TRATION (DIRECT NURS. HRS.)	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANS-PORTATION (MILEAGE)	VOLUNTEER SVC COOR-DINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)	PHYSICIAN ADMINISTRA-TIVE SVCS (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT / RESIDENTIAL CARE SVCS (IN-FACIL-ITY DAYS)	TOTAL	
		9	10	11	12	13	14	15	16	17	18	
	GENERAL SERVICE COST CENTERS											
1	Cap Rel Costs-Bldg & Fixt											1
2	Cap Rel Costs-Mvble Equip											2
3	Employee Benefits Department											3
4	Administrative & General											4
5	Plant Operation & Maintenance											5
6	Laundry & Linen Service											6
7	Housekeeping											7
8	Dietary											8
9	Nursing Administration											9
10	Routine Medical Supplies											10
11	Medical Records											11
12	Staff Transportation											12
13	Volunteer Service Coordination											13
14	Pharmacy											14
15	Physician Administrative Services											15
16	Other General Service											16
17	Patient/Residential Care Services											17
	LEVEL OF CARE											
50	Hospice Continuous Home Care											50
51	Hospice Routine Home Care											51
52	Hospice Inpatient Respite Care											52
53	Hospice General Inpatient Care											53
	NONREIMBURSABLE COST CENTERS											
60	Bereavement Program											60
61	Volunteer Program											61
62	Fundraising											62
63	Hospice/Palliative Medicine Fellows											63
64	Palliative Care Program											64
65	Other Physician Services											65
66	Residential Care											66
67	Advertising											67
68	Telehealth/Telemonitoring											68
69	Thrift Store											69
70	Nursing Facility Room & Board											70
71												71
99	Negative Cost Center											99
101	Cost to be allocated (per Wkst. O-6, Part I)											101
102	Unit cost multiplier											102

APPORTIONMENT OF HHA-BASED HOSPICE SHARED SERVICE COSTS BY LEVEL OF CARE

HHA CCN: _____
HOSPICE CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET O-7

	Cost Center Descriptions	Wkst. B, col. 10, line	Total HHA Costs	Total HHA Charges (from Provider Records)	Cost to Charge Ratio	Charges by LOC (from Provider Records) HCHC	HRHC	HIRC	HGIP	Shared Service Costs by LOC HCHC (col. 3 x col. 4)	HRHC (col. 3 x col. 5)	HIRC (col. 3 x col. 6)	HGIP (col. 3 x col. 7)	
		0	1	2	3	4	5	6	7	8	9	10	11	
	ANCILLARY SERVICE COST CENTERS													
1	Physical Therapy	18												1
2	Physical Therapy Assistant	19												2
3	Occupational Therapy	20												3
4	Certified Occupational Therapy Assistant	21												4
5	Speech-Language Pathology	22												5
6	Medical Social Services	23												6
7	Medical Supplies (see instructions)	25												7
8	Drugs	26												8
9	Durable Medical Equipment/Oxygen	28												9
10	Totals (sum of lines 1-9)													10

CALCULATION OF HHA-BASED HOSPICE PER DIEM COST		HHA CCN: _____ HOSPICE CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET O-8	
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1	2	3	
HOSPICE CONTINUOUS HOME CARE					
1	Total cost (Wkst. O-6, Part I, col. 18, line 50 plus Wkst. O-7, col. 8, line 9)				1
2	Total unduplicated days (Wkst. S-4, col. 4, line 1)				2
3	Total average cost per diem (line 1 divided by line 2)				3
4	Unduplicated program days (Wkst. S-4, col. as appropriate, line 1)				4
5	Program cost (line 3 times line 4)				5
HOSPICE ROUTINE HOME CARE					
6	Total cost (Wkst. O-6, Part I, col. 18, line 51 plus Wkst. O-7, col. 9, line 9)				6
7	Total unduplicated days (Wkst. S-4, col. 4, line 2)				7
8	Total average cost per diem (line 6 divided by line 7)				8
9	Unduplicated program days (Wkst. S-4, col. as appropriate, line 2)				9
10	Program cost (line 8 times line 9)				10
HOSPICE INPATIENT RESPITE CARE					
11	Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 10, line 9)				11
12	Total unduplicated days (Wkst. S-4, col. 4, line 3)				12
13	Total average cost per diem (line 11 divided by line 12)				13
14	Unduplicated program days (Wkst. S-4, col. as appropriate, line 3)				14
15	Program cost (line 13 times line 14)				15
HOSPICE GENERAL INPATIENT CARE					
16	Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 11, line 9)				16
17	Total unduplicated days (Wkst. S-4, col. 4, line 4)				17
18	Total average cost per diem (line 16 divided by line 17)				18
19	Unduplicated program days (Wkst. S-4, col. as appropriate, line 4)				19
20	Program cost (line 18 times line 19)				20
TOTAL HOSPICE CARE					
21	Total cost (sum of line 1 + line 6 + line 11 + line 16)				21
22	Total unduplicated days (Wkst. S-4, col. 4, line 5)				22
23	Average cost per diem (line 21 divided by line 22)				23

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