

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: 01/31/2027

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

Provider use only	1. <input type="checkbox"/> Electronically prepared cost report. 2. <input type="checkbox"/> Manually prepared cost report (limited to low or no utilization). 3. <input type="checkbox"/> If this is an amended cost report enter the number of times the provider resubmitted this cost report. 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, "N" for no utilization.	DATE: _____ TIME: _____ <input type="checkbox"/> If hospice only, enter "H".
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this HHA CCN 9. <input type="checkbox"/> Final Report for this HHA CCN 10. NPR Date: _____ 11. Contractor Vendor Code: _____ 12. <input type="checkbox"/> 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.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Printed Name			2
3	Title			3
4	Signature date			4

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 response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA 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.

FORM CMS-1728-20 (04-2024) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4704 - 4704.3)

IDENTIFICATION DATA				HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2, PART I
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HOME HEALTH AGENCY COMPLEX ADDRESS						
		STREET 1	P. O. BOX 2			
1	Address 1					1
		CITY 1	STATE 2	ZIP CODE 3		
2	Address 2					2

HOME HEALTH AGENCY COMPONENT IDENTIFICATION						
		COMPONENT NAME 1			PROVIDER CCN 2	DATE CERTIFIED 3
3	Home Health Agency					3
4	HHA-based Hospice					4
		From: 1	To: 2			
5	Cost Reporting Period:					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 HO/COs 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 1	PAID LOSSES 2	SELF-INSURANCE 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/CHAIN ORGANIZATION INFORMATION								
		RECEIVE ALLOCATION 1	NUMBER OF ORGANIZATIONS 2					
16	HO/CO cost allocation					16		
		NAME 1	CCN 2	CONTRACTOR NUMBER 3	STREET ADDRESS 4	CITY 5	STATE 6	ZIP CODE 7
17	HO/CO Information							17

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

		Y/N 1	DATE 2	V/I 3	
1	Has the HHA changed ownership prior to the beginning of this cost reporting period? (see instructions) Enter "Y" for yes or "N" for no in column 1. If yes, enter the date of the change in column 2. (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 1	A / C / R 2	DATE 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.				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 1	DATE 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, in column 2, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (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, in column 2, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (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

	FIRST NAME 1	LAST NAME 2	TITLE 3	
15	Preparer			15
16	Employer Name			16
	TELEPHONE NUMBER 1	EMAIL ADDRESS 2		
17	Contact			17

STATISTICAL DATA	HHA CCN: _____ _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PARTS I, II, & III
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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 - RN									1
2 Skilled Nursing Care - LPN									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)

DESCRIPTION	STAFF			CONTRACT			TOTAL			
	1			2			3			
	1	2	3	1	2	3	1	2	3	
14 Number of hours in your normal work week										14
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 Physical Therapy Supervisor										21
22 Physical Therapists										22
23 Physical Therapy Assistants										23
24 Occupational Therapy Supervisor										24
25 Occupational Therapists										25
26 Occupational Therapy Assistants										26
27 Speech-Language Pathology Supervisor										27
28 Speech-Language Pathologists										28
29 Medical Social Services Supervisor										29
30 Medical Social Services										30
31 Home Health Aide Supervisor										31
32 Home Health Aides										32
33										33

PART III - CORE BASED STATISTICAL AREA DATA

DESCRIPTION	1	
34 Enter the total number of CBSAs where Medicare covered services were provided during the cost reporting period.		34
	CBSA Codes	
35 List all CBSA codes for areas where Medicare covered home health services were provided. (see instructions)		35

STATISTICAL DATA	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART IV
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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
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OCCUPATIONAL CATEGORY	AMOUNT REPORTED 1	FRINGE BENEFITS 2	ADJUSTED SALARIES 3	PAID HOURS RELATED TO SALARY 4	AVERAGE HOURLY WAGE 5	
Direct Salaries						
Nursing Occupations						
1 Nursing Supervisor						1
2 Registered Nurses						2
3 Licensed Practical Nurses						3
4 Total Nursing (sum of lines 1 through 3)						4
5 Physical Therapy Supervisor						5
6 Physical Therapists						6
7 Physical Therapy Assistants						7
8 Occupational Therapy Supervisor						8
9 Occupational Therapists						9
10 Occupational Therapy Assistants						10
11 Speech-Language Pathology Supervisor						11
12 Speech-Language Pathologists						12
13 Other Medical Staff						13
Contract Labor						
Nursing Occupations						
14 Nursing Supervisor						14
15 Registered Nurses						15
16 Licensed Practical Nurses						16
17 Total Nursing (sum of lines 14 through 16)						17
18 Physical Therapy Supervisor						18
19 Physical Therapists						19
20 Physical Therapy Assistants						20
21 Occupational Therapy Supervisor						21
22 Occupational Therapists						22
23 Occupational Therapy Assistants						23
24 Speech-Language Pathology Supervisor						24
25 Speech-Language Pathologists						25
26 Other Medical Staff						26

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

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			
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	ADJUSTMENTS	EXPENSES FOR COST ALLOCATION	
		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	Telecommunications Technology										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 - RN										16
17	1700	Skilled Nursing Care - LPN										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 Charged to Patients										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 (see instructions)										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

ADJUSTMENTS TO EXPENSES		HHA CCN:	PERIOD:	WORKSHEET A-8	
		_____	FROM: _____ TO: _____		
DESCRIPTION ¹	BASIS / CODE ²	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
	1		2	COST CENTER	
			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)	WKST 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					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
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50	TOTAL (sum of lines 1 through 49)				50

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

²Basis for adjustment (see instructions)

- A. Costs - if cost, including applicable overhead, can be determined
- B. Amount Received - If cost cannot be determined

COST ALLOCATION ALLOCATION OF GENERAL SERVICE COSTS						HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B	
	NET EXPENSES FOR COST ALLOCATION	CAP REL BLDGS & FIXTURES	CAP REL MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	TRANS- PORTATION	SUBTOTAL	TELE- COMMUN. TECHNOLOGY		
	0	1	2	3	4	4A	5		
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	Telecommunications Technology							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 - RN							16	
17	Skilled Nursing Care - LPN							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 Charged to Patients							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 ALLOCATION OF GENERAL SERVICE COSTS					HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B	
	SUBTOTAL	ADMINISTRATIVE & GENERAL	NURSING ADMINISTRATION	SUBTOTAL	MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
	5A	6	7	7A	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	Telecommunications Technology							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 - RN							16
17	Skilled Nursing Care - LPN							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 Charged to Patients							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	CAP REL BLDGS & FIXTURES (SQUARE FEET)	CAP REL MOVABLE EQUIPMENT (DOLLAR VALUE)	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANS- PORTATION (MILEAGE)	RECONCIL- IATION	TELE- COMMUN. TECHNOLOGY (ACCUM. COST)	
	1	2	3	4	5A	5	
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	Telecommunications Technology						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 - RN						16
17	Skilled Nursing Care - LPN						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 Charged to Patients						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

COST ALLOCATION STATISTICAL BASES						HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B-1	
		RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 6	NURSING ADMINISTRATION (DIRECT NURS HRS) 7	RECONCILIATION 8A	MEDICAL RECORDS (ACCUM. COST) 8	OTHER GENERAL SERVICE (SPECIFY) 9	TOTAL 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	Telecommunications Technology								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 - RN								16
17	Skilled Nursing Care - LPN								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 Charged to Patients								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		FROM WKST. B, COL. 10, LINE:	TOTAL		AVERAGE COST PER VISIT	HHA MEDICARE PROGRAM VISITS	HHA MEDICARE PROGRAM COSTS	
			COST	VISITS				
			1	2				
1	Skilled Nursing Care - RN	16						1
2	Skilled Nursing Care - LPN	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	RATIO	MEDICARE COVERED CHARGES			COST OF MEDICARE SERVICES				
						OPPS REIMBURSED SERVICES	HHA SERVICES		OPPS REIMBURSED SERVICES	HHA SERVICES			
							NOT SUBJECT TO DED & COINSUR	SUBJECT TO DED & COINSUR		NOT SUBJECT TO DED & COINSUR	SUBJECT TO DED & COINSUR		
							1	2		3	4		5
11	Cost of Medical Supplies	25											11
12	Cost of Drugs	26											12
13	Cost of Administering Vaccines	27											13
14	Disposable Devices	29											14

CALCULATION OF REIMBURSEMENT SETTLEMENT	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET D
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PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES FOR VACCINES

		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 1	SUBJECT TO DEDUCTIBLES & COINSURANCE 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 (see instructions)		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 15, plus lines 17 through 20, minus lines 16, 21, and 22)		23
24	Coinsurance billed to Medicare patients (from your records)		24
25	Allowable bad debts (see instructions)		25
26	Adjusted reimbursable bad debts (see instructions)		26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (line 23 minus line 24, plus line 26)		28
29			29
30	Other demonstration payment adjustment amount before sequestration		30
31	Amount due HHA prior to sequestration adjustment (line 28 minus lines 29 through 30)		31
32	Sequestration adjustment (see instructions)		32
32.75	Sequestration adjustment for non-claims based amounts (see instructions)		32.75
33	Amount due HHA after sequestration adjustment (line 31 minus lines 32 and 32.75)		33
34	Other demonstration payment adjustment amount after sequestration		34
35	Amount due HHA (line 33 minus line 34)		35
36	Total interim payments (from Worksheet D-1, line 4)		36
37	Tentative settlement (For contractor use only)		37
38	Balance due HHA/Medicare program (line 35 minus lines 36 and 37) (indicate overpayments in brackets)		38
39	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		39

ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	HHA CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET D-1
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DESCRIPTION		DATE		AMOUNT	
		1	2	1	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 through 3.49, minus sum of lines 3.50 through 3.98)		.99		3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Worksheet D, Part II, line 36)				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
			.50		5.50
		Provider to Program	.51		5.51
			.52		5.52
			.99		5.99
			SUBTOTAL (sum of lines 5.01 through 5.49, minus sum of lines 5.50 through 5.98)		
6	Determine net settlement amount (balance due) based on the cost report.	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		8

¹On lines 3 and 5, 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.