DRAFT FORM CMS-1728-20

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).

HOME HEALTH AGENCY COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	HHA CCN: ____________________	PERIOD: FROM: _____________ TO: ________________

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. Contractor Vendor Code: _ 12. [ ] If line 5, column 1 is 4: 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 OTHERWIS 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
		1
1	HOME HEALTH AGENCY	

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.

4795 (Cont.)

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

WORKSHEET S
PARTS I, II & III

: Enter the number of

;E

XVIII	
	1

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r

IDENTIFICATION DATA					HHA CCN: ____________	PERIOD: FROM: ________ TO: ________

HOME HEALTH AGENCY COMPLEX ADDRESS

		STREET	P. O. BOX
		1	2
1	Address 1		

		CITY	STATE	ZIP CODE
		1	2	3
2	Address 1			

HOME HEALTH AGENCY COMPONENT IDENTIFICATION

		COMPONENT NAME	PROVIDER CCN
		1	2
3	Home Health Agency		
4	HHA-based Hospice		

		From:	To:
		1	2
5	Cost Reporting Period:		

6	Type of control (see instructions)
7	Does the HHA qualify as a nominal charge provider (see 42 CFR 409.3)?
8	Does the HHA contract with outside suppliers for physical therapy services?
9	Does the HHA contract with outside suppliers for occupational therapy services?
10	Does the HHA contract with outside suppliers for speech therapy services?
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.

MALPRACTICE INSURANCE INFORMATION

		PREMIUMS	PAID LOSSES
		1	2
12	Is this HHA legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		
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.		
14	List amounts of malpractice premiums, paid losses, and self-insurance in the applicable columns.		
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.		

	HOME OFFICE INFORMATION	1
16	Does this HHA receive an allocation of costs from more than one home office? (see instructions)	
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, complete line 18.	

		HOME OFFICE NAME	HOME OFFICE NUMBER	HOME OFFICE CONTRACTOR NUMBER	STREET ADDRESS	CITY	STATE
		1	2	3	4	5	6
18	Home Office Information						

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WORKSHEET S-2,
PART I

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DATE CERTIFIED	
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SELF-INSURANCE	
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	16
	17
ZIP CODE	
7	
	18

REIMBURSEMENT DATA		HHA CCN: ____________________	PERIOD: FROM: _____________ TO: _______________

PROVIDER ORGANIZATION AND OPERATION

		Y/N	Date
		1	2
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)		
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.		
3	Is the HHA involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply 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)		

FINANCIAL DATA AND REPORTS

		Y/N	A / C / R
		1	2
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 financialstatements or enter date available in column 3.		
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.		

BAD DEBT

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

PS&R REPORT DATA

		Y/N
		1
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.)	
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)	
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.	
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.	
13	If line 9 or 10 is yes, were adjustments made to PS&R Report data for Other? If yes, describe the other adjustments: ___________________________________	
14	Was the cost report prepared only using the HHA's records? Enter "Y" for yes or "N" for no. If yes, see instructions.	

COST REPORT PREPARER CONTACT INFORMATION

		FIRST NAME	LAST NAME	Ti
		1	2	3
15	Preparer			
16	Employer Name			

		TELEPHONE NUMBER	EMAIL ADDRESS
		1	2
17	Contact		

WORKSHEET S-2,
PART II

V/I	
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Date	
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STATISTICAL DATA	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________	WORKSHEET S PARTS I, II, & I

PART I - VISITS DATA

	DESCRIPTION	TITLE XVIII - MEDICARE		TITLE XIX - MEDICAID		OTHER		TOT
		VISITS	PATIENT CENSUS	VISITS	PATIENT CENSUS	VISITS	PATIENT CENSUS	VISITS
		1	2	3	4	5	6	7
1	Skilled Nursing Care - Registered Nurse							
2	Skilled Nursing Care - Licensed Practical Nurse							
3	Physical Therapy							
4	Physical Therapy Assistant							
5	Occupational Therapy							
6	Certified Occupational Therapy Assistant							
7	Speech-Language Pathology							
8	Medical Social Service							
9	Home Health Aide							
10	All Other Services							
11	Total Visits							
12	Home Health Aide Hours							
13	Unduplicated Census Count							

PART II - EMPLOYMENT DATA (FULL TIME EQUIVALENT)

		STAFF	CONTRACT	TOT
14	Number of hours in your normal work week			
		1	2	3
15	Administrator and Assistant Administrator(s)			
16	Director and Assistant Director(s)			
17	Other Administrative Personnel			
18	Nursing Supervisor			
19	Registered Nurses			
20	Licensed Practical Nurses			
21	Physical Therapy Supervisor			
22	Physical Therapists			
23	Physical Therapy Assistants			
24	Occupational Therapy Supervisor			
25	Occupational Therapists			
26	Occupational Therapy Assistants			
27	Speech-Language Pathology Supervisor			
28	Speech-Language Pathologists			
29	Medical Social Services Supervisor			
30	Medical Social Services			
31	Home Health Aide Supervisor			
32	Home Health Aides			
33				

PART III - CORE BASED STATISTICAL AREA DATA

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

S-3

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PATIENT CENSUS	
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Codes	
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Rev. 1

STATISTICAL DATA	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________

PART IV - PPS ACTIVITY DATA

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

WORKSHEET S-3
PART IV

TOTAL EIPSODES/ PERIODS	
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STATISTICAL DATA DIRECT CARE EXPENDITURES				HHA CCN: ________________	PERIOD: FROM: ____________ TO: ______________

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

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WORKSHEET S-3
PART V

AVERAGE HOURLY WAGE	
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HHA-BASED HOSPICE STATISTICAL DATA	HHA CCN: ________________ HOSPICE CCN: ________________	PERIOD: FROM: ___________ TO: ______________

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS		
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	OTHER
		1	2	3
1	Hospice Continuous Home Care			
2	Hospice Routine Home Care			
3	Hospice Inpatient Respite Care			
4	Hospice General Inpatient Care			
5	Total Hospice Days			

PART II - CONTRACTED STATISTICAL DATA

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	OTHER
		1	2	3
6	Hospice Inpatient Respite Care			
7	Hospice General Inpatient Care			

WORKSHEET S-4
PARTS I & II

TOTAL	
4	
	1
	2
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	5

TOTAL	
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	6
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

HHA CCN: ____________________

PERIOD:
FROM: ______________
TO: _________________

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

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WORKSHEET A

EXPENSES FOR COST ALLOCATION	
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RECLASSIFICATIONS							HHA CCN: ____________		PERIOD: FROM: ____________ TO: ____________
			INCREASE				DECREASE		
		CODE[1]	COST CENTER	WS A LINE NO.	SALARY[2]	OTHER[2]	COST CENTER	WS A LINE NO.	SALARY[2]
	EXPLANATION OF RECLASSIFICATION(S)	1	2	3	4	5	6	7	8
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100	TOTAL RECLASSIFICATIONS								

[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.

WORKSHEET A-6

OTHER[2]	
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ADJUSTMENTS TO EXPENSES		HHA CCN: ____________	PERIOD: FROM: ________ TO: ________
			EXPENSE CLAS WORKSHEET A T THE AMOUNT IS
	BASIS / CODE[2]	AMOUNT	Cost Center
DESCRIPTION[1]	1	2	3
1 Excess funds generated from operations, other than net income			
2 Trade, quantity, time and other discounts on purchases (chapter 8)			
3 Rebates and refunds of expenses (chapter 8)			
4 Related organization transactions (chapter 10)	WKST A-8-1		
5 Sale of medical records and abstracts			
6 Income from imposition of interest, finance or penalty charges			
7 Sale of medical and surgical supplies to other than patients			
8 Sale of Drugs to other than patients			
9 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			
10 Lobbying Activities (chapter 21)			
11 Advertising costs (chapter 21)			
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50 TOTAL (sum of lines 1 through 49)			

[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

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WORKSHEET A-8

SIFICATION ON TO/FROM WHICH TO BE ADJUSTED	
Line No.	
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FORM CMS-1728-20

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________

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

	WKST A LINE NO.	COST CENTER	EXPENSE ITEM	PART II LINE NO.	H.O. W/S S-2, PART I	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A, COL. 8
	1	2	3	4	5	6	7
1							
2							
3							
4							
5							
50	TOTALS (sum of lines 1 through 49) Transfer col. 8, line 50, to Wkst. A-8, line 4, col. 2.						

* The amounts on lines 1 through 49 (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 6 of this section.

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

THE SECRETARY, BY VIRTUE OF THE 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 & MEDICAID SERVICES AND ITS CONTRACTORS IN DETERMINING 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 PROVID 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 ORGANIZATIONS AND/OR HOME OFFICE	
	SYMBOL[1]	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP
	1	2	3	4	5
1					
2					
3					
4					
5					
50					

[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 ___________________________.

WORKSHEET A-8-1

NET ADJUSTMENTS	
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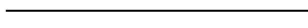
0	3
0	4
0	5
	50



)E

TYPE OF BUSINESS	
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COST ALLOCATION - GENERAL SERVICE COST				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	SUBTOTAL (cols. 0-4)	ADMINISTRA-TIVE & GENERAL	TOTAL	
		BLDGS & & FIXTURES	MOVABLE EQUIPMENT						
	0	1	2	3	4	4A	5	6	
GENERAL SERVICE COST CENTERS									
1 Capital Related - Bldg. and Fixtures		0							1
2 Capital Related - Movable Equipment		0	0						2
3 Plant Operation & Maintenance		0	0	0					3
4 Transportation (See Instructions)		0	0	0					4
5 Administrative and General									5
6 Other (specify)									
HHA REIMBURSABLE SERVICES									
16 Skilled Nursing Care - Registered Nurse		0	0	0			0		16
17 Skilled Nursing Care - Licensed Practical Nurse									17
18 Physical Therapy							0		18
19 Physical Therapy Assistant									19
20 Occupational Therapy							0		20
21 Certified Occupational Therapy Assistant									21
22 Speech Pathology							0		22
23 Medical Social Services							0		23
24 Home Health Aide							0		24
25 *Medical* Supplies (see instructions)		0	0	0			0		25
26 Drugs		0	0	0			0		26
27 Cost of Administering Vaccines									27
28 DME		0	0	0			0		28
29 Other (specify)									
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
47 Other (specify)									47
57 Hospice									57

Darryl Simms:
Ensure that line numbers & cost center labels match those on WS A. Same for the WS below. On worksheet B skilled nursing care is line 6, however on worksheet A it is line 17 what should I do because it would be out of order. Done AD

COST ALLOCATION - STATISTICAL BASIS	HHA CCN: ____________	PERIOD: FROM ____________ TO ____________	WORKSHEET B-1

		CAPITAL RELATED COSTS							
		& FIXTURES FEET)	EQUIPMENT	PLANT MAINTENANCE FEET)	TRANS- (MILEAGE)	IATION	ADMINISTRA- & GENERAL LATED COST)	TOTAL	
		1		3	4	5A	5	6	
	GENERAL SERVICE COST CENTER								
1	Capital Related - Bldg. and Fixtures								1
2	Capital Related - Movable Equipment								2
3	Plant Operation & Maintenance								3
4	Transportation (See Instructions)								4
5	Administrative and General								5
6	Other (specify)								6
	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 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	DME								28
29	Disposable Devices								
30	Other (specify)								29
	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	Other (specify)								47
	SPECIAL PURPOSE COST CENTER								
57	Hospice								57
58	Other (specify)								58
	Total								100
101	Cost To Be Allocated (Per Wkst B)								101
102	Unit Cost Multiplier								102

Darryl Simms:
Ensure that line numbers & cost center labels match those on WS A. Done AD

Darryl Simms:
Change "total" line to 100. Done AD

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

WORKSHEET B COST ALLOCATION
ALLOCATION OF GENERAL SERVICE COSTS

TELE-COMMUN. TECHNOLOGY				SUBTOTAL	ADMINISTRATIVE & GENERAL	NURSING ADMINISTRATION	SUBTOTAL
5				5A	6	7	7A
			GENERAL SERVICE COST CENTERS				
	1	1	Capital Related - Buildings and Fixtures				
	2	2	Capital Related - Movable Equipment				
	3	3	Plant Operation & Maintenance				
	4	4	Transportation (see instructions)				
	5	5	Telecommunications Technology				
	6	6	Administrative and General				
	7	7	Nursing Administration				
	8	8	Medical Records				
	9	9	Other General Service				
			HHA REIMBURSABLE SERVICES				
	16	16	Skilled Nursing Care - Registered Nurse		0		
	17	17	Skilled Nursing Care - Licensed Practical Nurse				
	18	18	Physical Therapy		0		
	19	19	Physical Therapy Assistant				
	20	20	Occupational Therapy		0		
	21	21	Certified Occupational Therapy Assistant				
	22	22	Speech-Language Pathology		0		
	23	23	Medical Social Services		0		
	24	24	Home Health Aide		0		
	25	25	Medical Supplies Charged to Patients		0		
	26	26	Drugs		0		
	27	27	Cost of Administering Vaccines				
	28	28	Durable Medical Equipment/Oxygen		0		
	29	29	Disposable Devices				
	30	30					
			HHA NONREIMBURSABLE SERVICES				
	39	39	Home Dialysis Aide Services				
	40	40	Respiratory Therapy				
	41	41	Private Duty Nursing				
	42	42	Clinic				
	43	43	Health Promotion Activities				
	44	44	Day Care Program				
	45	45	Home Delivered Meals Program				
	46	46	Homemaker Services				
	47	47	Telehealth				
	48	48	Advertising				
	49	49	Fundraising				
	50	50					
			SPECIAL PURPOSE COST CENTER				
	57	57	Hospice				
	58	58					
	100	100	Total		0		

HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________	WORKSHEET B	
MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
8	9	10	
			1
			2
			3
			4
			5
			6
			7
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			9
			16
			17
			18
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			57
			58
			100

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

COST ALLOCATION
STATISTICAL BASES

TELE-COMMUN. TECHNOLOGY (ACCUM. COST)				RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL (ACCUM. COST)	NURSING ADMINISTRA-TION (DIRECT NURS HRS)	RECONCIL-IATION
5				6A	6	7	8A
			GENERAL SERVICE COST CENTER				
	1	1	Capital Related - Buildings and Fixtures				
	2	2	Capital Related - Movable Equipment				
	3	3	Plant Operation & Maintenance				
	4	4	Transportation (see instructions)				
	5	5	Telecommunications Technology				
	6	6	Administrative and General				
	7	7	Nursing Administration				
	8	8	Medical Records				
	9	9	Other General Service				
			HHA REIMBURSABLE SERVICES				
	16	16	Skilled Nursing Care - Registered Nurse				
	17	17	Skilled Nursing Care - Licensed Practical Nurse				
	18	18	Physical Therapy				
	19	19	Physical Therapy Assistant				
	20	20	Occupational Therapy				
	21	21	Certified Occupational Therapy Assistant				
	22	22	Speech-Language Pathology				
	23	23	Medical Social Services				
	24	24	Home Health Aide				
	25	25	Medical Supplies Charged to Patients				
	26	26	Drugs				
	27	27	Cost of Administering Vaccines				
	28	28	Durable Medical Equipment/Oxygen				
	29	29	Disposable Devices				
	30	30					
			HHA NONREIMBURSABLE SERVICES				
	39	39	Home Dialysis Aide Services				
	40	40	Respiratory Therapy				
	41	41	Private Duty Nursing				
	42	42	Clinic				
	43	43	Health Promotion Activities				
	44	44	Day Care Program				
	45	45	Home Delivered Meals Program				
	46	46	Homemaker Services				
	47	47	Telehealth				
	48	48	Advertising				
	49	49	Fundraising				
	50	50					
			SPECIAL PURPOSE COST CENTER				
	57	57	Hospice				
	58	58					
	100	100	Cost To Be Allocated (per wkst B)				
	101	101	Unit Cost Multiplier				

HHA CCN: ______________	PERIOD: FROM: ______________ TO: ______________	WORKSHEET B-1	
MEDICAL RECORDS (ACCUM. COST)	OTHER GENERAL SERVICE (SPECIFY)	TOTAL	
8	9	10	
			1
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			100
			101

APPORTIONMENT OF PATIENT SERVICE COSTS	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________

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 COST	TOTAL VISITS	AVERAGE COST PER VISIT	HHA MEDICARE PROGRAM VISITS
		1	2	3	4	5
1	Skilled Nursing Care - Registered Nurse	16				
2	Skilled Nursing Care - Licensed Practical Nurse	17				
3	Physical Therapy	18				
4	Physical Therapy Assistant	19				
5	Occupational Therapy	20				
6	Certified Occupational Therapy Assistant	21				
7	Speech-Language Pathology	22				
8	Medical Social Services	23				
9	Home Health Aide Services	24				
10	Total (sum of lines 1-9)					

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

	OTHERE PATIENT SERVICES	FROM WKST. B, COL. 10 LINE:	TOTAL COST	TOTAL CHARGES	RATIO	MEDICARE COVERED CHARGES OPPS REIMBURSED SERVICES	MEDICARE COVERED CHARGES HHA SERVICES NOT SUBJECT TO DED & COINSUR	MEDICARE COVERED CHARGES HHA SERVICES SUBJECT TO DED & COINSUR	COST OF MEDICARE SER OPPS REIMBURSED SERVICES	COST OF MEDICARE SER HHA SE NOT SUBJECT TO DED & COINSUR
			1	2	3	4	5	6	7	8
11	Cost of Medical Supplies	25								
12	Cost of Drugs	26								
13	Cost of Administering Vaccines	27								
14	Disposable Devices	29								

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WORKSHEET C
PARTS I & II

HHA MEDICARE PROGRAM COSTS	
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VICES	
RVICES	
SUBJECT TO DED & COINSUR	
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CALCULATION OF REIMBURSEMENT SETTLEMENT	HHA CCN: ________________	PERIOD: FROM: _____________ TO: _______________

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

		NOT SUBJECT TO DEDUCTIBLES & COINSURANCE
		1
1	Reasonable cost of vaccines (see instructions)	
2	Total vaccines charges	
3	Aggregate amount actually collected from patients liable for payment for services on a charge basis (from your records)	
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)	
5	Ratio of line 3 to 4 (not to exceed 1.000000)	
6	Total customary charges (multiply line 5 by line 2 for columns 1 and 2) (see instructions)	
7	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) (see instructions)	
8	Excess of reasonable cost over customary charges (see instructions)	
9	Subtotal of Reasonable Cost (see instructions)	

PART II - COMPUTATION OF REIMBURSEMENT SETTLEMENT

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

WORKSHEET D

SUBJECT TO DEDUCTIBLES & COINSURANCE	
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ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________	WORKSHEE

	DESRIPTION			DATE	AMOUN
				1	2
1	Total interim payments paid to HHA				
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.				
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		
			.02		
			.03		
			.04		
			.05		
		Provider to Program	.50		
			.51		
			.52		
			.53		
			.54		
	SUBTOTAL (sum of lines 3.01 through 3.49, minus sum of lines 3.50 through 3.98)		.99		
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Worksheet D, Part II, line 36)				
	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		
			.02		
			.03		
		Provider to Program	.50		
			.51		
			.52		
	SUBTOTAL (sum of lines 5.01 through 5.49, minus sum of lines 5.50 through 5.98)		.99		
6	Determine net settlement amount (balance due) based on the cost report. [1]	Program to Provider	.01		
		Provider to Program	.02		
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)				
	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DAT
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.

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	5.99
	6.01
	6.02
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TE	8

BALANCE SHEET	HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________

	ASSETS (Omit Cents)
	CURRENT ASSETS
1	Cash on hand and in banks
2	Temporary investments
3	Notes receivable
4	Accounts receivable
5	Other receivables
6	Less: allowances for uncollectible notes and accounts receivable
7	Inventory
8	Prepaid expenses
9	Other current assets
10	TOTAL CURRENT ASSETS (sum of lines 1 through 9)
	FIXED ASSETS
11	Land
12	Land Improvements
13	Less: accumulated depreciation
14	Buildings
15	Less: accumulated depreciation
16	Leasehold improvements
17	Less: accumulated depreciation
18	Fixed equipment
19	Less: accumulated depreciation
20	Automobiles and trucks
21	Less: Accumulated Depreciation
22	Major movable equipment
23	Less: accumulated depreciation
24	Minor equipment
25	Less: Accumulated depreciation
26	Minor equipment nondepreciable
27	TOTAL FIXED ASSETS (sum of lines 11 through 26)
	OTHER ASSETS
28	Investments
29	Deposits on leases
30	Due from owners/officers
31	TOTAL OTHER ASSETS (sum of lines 28 through 30)
32	TOTAL ASSETS (sum of lines 10, 27 and 31)
	LIABILITIES AND FUND BALANCE (Omit Cents)
	CURRENT LIABILITIES
33	Accounts payable
34	Salaries, wages & fees payable
35	Payroll taxes payable
36	Notes and payable loans (short term)
37	Deferred income
38	Accelerated payments
39	Other current liabilities
40	TOTAL CURRENT LIABILITIES (sum of lines 33 through 39)
	LONG TERM LIABILITIES
41	Mortgage payable
42	Notes payable
43	Unsecured loans
44	Other long term liabilities
45	TOTAL LONG TERM LIABILITIES (sum of lines 41 through 44)
46	TOTAL LIABILITIES (sum of lines 40 and 45)
	CAPITAL ACCOUNTS
47	FUND BALANCES
48	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 46 and 47)

WORKSHEET F

AMOUNT	
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AMOUNT	
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STATEMENT OF REVENUES AND EXPENSES		HHA CCN: ____________	PERIOD: FROM: ____________ TO: ____________

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	OTHER
		1	2	3
1	Gross patient revenues			
2	Less: Allowances and discounts on patients' accounts			
3	Net patient revenues (line 1 minus line 2)			

		1
4	Operating expenses (from Wkst. A, line 100, col. 6)	
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17	Less total operating expenses (sum of lines 4 through 16)	
18	Net income from service to patients (line 3 minus line 17)	
	Other income:	
19	Contributions, donations, bequests, etc.	
20	Income from investments	
21	Purchase discounts	
22	Rebates and refunds of expenses	
23	Sale of Medical and Nursing Supplies to other than patients	
24	Sale of durable medical equipment to other than patients	
25	Sale of drugs to other than patients	
26	Sale of medical records and abstracts	
27	Government Appropriations	
28		
29		
30		
31		
32	Total Other Income (sum of lines 19 through 31)	
33	Net Income or Loss for the period (line 18 plus line 32)	

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WORKSHEET F-1

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

* 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: ______________

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

* 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.

WORKSHEET O

TOTAL	
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WORKSHEET O

TOTAL	
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ANALYSIS OF HHA-BASED HOSPICE COSTS CONTINUOUS HOME CARE	HHA CCN: ________________ HOSPICE CCN: ________________	PERIOD: FROM: ___________ TO: ______________

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

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

WORKSHEET O-1

TOTAL	
7	
	25
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	38
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	41
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	45
	46
	47
	100

ANALYSIS OF HHA-BASED HOSPICE COST
ROUTINE HOME CARE

HHA CCN: ________________
HOSPICE CCN: ________________

PERIOD:
FROM: ___________
TO: ______________

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

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

WORKSHEET O-2

TOTAL	
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	45
	46
	47
	100

ANALYSIS OF HHA-BASED HOSPICE COSTS INPATIENT RESPITE CARE	HHA CCN: ____________ HOSPICE CCN: ____________	PERIOD: FROM: ___________ TO: ______________

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

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

WORKSHEET O-3

TOTAL	
7	
	25
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	44
	45
	46
	47
	100

ANALYSIS OF HHA-BASED HOSPICE COSTS
GENERAL INPATIENT CARE

HHA CCN: ________________
HOSPICE CCN: ________________

PERIOD:
FROM: ___________
TO: ______________

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

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

WORKSHEET O-4

TOTAL	
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	47
	100

DETERMINATION OF HHA-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION	HHA CCN: ____________________ HOSPICE CCN: ____________________	PERIOD: FROM: ______________ TO: _________________

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

WORKSHEET O-5

TOTAL EXPENSES	
3	
	1
	2
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	71
	99
	100

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

HHA CCN: ____________
HOSPICE CCN: ____________

PERIOD:
FROM: ____________
TO: ____________

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

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS

HHA CCN: ____________________

HOSPICE CCN: ____________________

PERIOD:
FROM: ________________
TO: ___________________

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

WORKSHEET O-6
PART I

DIETARY	
8	
	1
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	63
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	71
	99
	100

WORKSHEET O-6
PART I

TOTAL	
18	
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	99
	100

4795 (Cont.)

COST ALLOCATION - HHA-BASED HOSPICE

STATISTICAL BASES

Cost Center Descriptions

GENERAL SERVICE COST CENTERS

1	Cap Rel Costs-Bldg & Fixt
2	Cap Rel Costs-Mvble Equip
3	Employee Benefits Department
4	Administrative & General
5	Plant Operation & Maintenance
6	Laundry & Linen Service
7	Housekeeping
8	Dietary
9	Nursing Administration
10	Routine Medical Supplies
11	Medical Records
12	Staff Transportation
13	Volunteer Service Coordination
14	Pharmacy
15	Physician Administrative Services
16	Other General Service
17	Patient/Residential Care Services

LEVEL OF CARE

50	Hospice Continuous Home Care
51	Hospice Routine Home Care
52	Hospice Inpatient Respite Care
53	Hospice General Inpatient Care

NONREIMBURSABLE COST CENTERS

60	Bereavement Program
61	Volunteer Program
62	Fundraising
63	Hospice/Palliative Medicine Fellows
64	Palliative Care Program
65	Other Physician Services
66	Residential Care
67	Advertising
68	Telehealth/Telemonitoring
69	Thrift Store
70	Nursing Facility Room & Board
71	
99	Negative Cost Center

CAP REL
BLDG
& FIX
(SQUARE
FEET)

1

FORM CMS-1728-20

CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	RECONCIL- IATION
2	3	4A

HHA CCN: ____________

HOSPICE CCN: ____________

ADMINIS-TRATIVE & GENERAL (ACCUM. COST)	*PLANT OP & MAINT (SQUARE FEET)*
4	*5*

PERIOD:
FROM: ________________
TO: ___________________

WORKSHEET O-6
PART II

LAUNDRY & LINEN (IN-FACILITY DAYS)	*HOUSE-KEEPING (SQUARE FEET)*
6	*7*

DRAFT

DIETARY

(IN-FACIL-
ITY DAYS)

8

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66
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71

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

	Cost Center Descriptions
	ANCILLARY SERVICE COST CENTERS
1	*Physical Therapy*
2	*Physical Therapy Assistant*
3	*Occupational Therapy*
4	*Certified Occupational Therapy Assistant*
5	*Speech-Language Pathology*
6	*Medical Social Services*
7	*Medical Supplies (see instructions)*
8	*Drugs*
9	*Durable Medical Equipment/Oxygen*

WKST. B, COL. 10, LINE	TOTAL HHA COSTS	TOTAL HHA CHARGES
0	1	2
18		
19		
20		
21		
22		
23		
25		
26		
28		

FORM CMS-1728-20

COST TO CHARGE RATIO	*CHARGES BY LOC*		
	HCHC	*HRHC*	*HIRC*
3	*4*	*5*	*6*

HHA CCN: ____________________

HOSPICE CCN: ____________________

PERIOD:
FROM: _______________
TO: __________________

SHARED SERVICE COSTS BY LOC

HGIP	*HCHC*	*HRHC*
7	*8*	*9*

DRAFT

WORKSHEET O-7

HIRC *HGIP*

10 *11*

1
2
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8

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

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WORKSHEET O-8

TOTAL	
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Rev. 1