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

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, "N" for no utilization, *or "H" for hospice only*.		
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: 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

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

HOME HEALTH AGENCY COMPLEX ADDRESS

		STREET	P. O. BOX					
		1	2					
1	Address 1							1
		CITY	STATE	ZIP CODE				
		1	2	3				
2	Address 2							2

HOME HEALTH AGENCY COMPONENT IDENTIFICATION

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

		From:	To:		
		1	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	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/CHAIN ORGANIZATION INFORMATION

		RECEIVE ALLOCATION	NUMBER OF ORGANIZATIONS						
		1	2						
16	HO/CO cost allocation								16
		NAME	CCN	CONTRACTOR NUMBER	STREET ADDRESS	CITY	STATE	ZIP CODE	
		1	2	3	4	5	6	7	
17	HO/CO Information								17

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 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 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.				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

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

		TELEPHONE NUMBER	EMAIL ADDRESS	
		1	2	
17	Contact			17

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

PART I - VISITS DATA

	DESCRIPTION	TITLE XVIII - MEDICARE VISITS	TITLE XVIII - MEDICARE PATIENT CENSUS	TITLE XIX - MEDICAID VISITS	TITLE XIX - MEDICAID PATIENT CENSUS	OTHER VISITS	OTHER PATIENT CENSUS	TOTAL VISITS	TOTAL 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)

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	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

		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

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

	OCCUPATIONAL CATEGORY	AMOUNT REPORTED	FRINGE BENEFITS	ADJUSTED SALARIES	PAID HOURS RELATED TO SALARY	AVERAGE HOURLY WAGE	
		1	2	3	4	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: _____ 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	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

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

	EXPLANATION OF RECLASSIFICATION(S)	CODE[1]	INCREASE				DECREASE				
			COST CENTER	WS A LINE NO.	SALARY[2]	OTHER[2]	COST CENTER	WS A LINE NO.	SALARY[2]	OTHER[2]	
		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										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)	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

[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

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

PART I - ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS AND/OR HOME OFFICE/CHAIN ORGANIZATIONS

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

* 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 BETWEEN RELATED ORGANIZATIONS AND/OR HOME OFFICE/CHAIN ORGANIZATIONS

THE SECRECTARY, 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 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 ORGANIZATIONS AND/OR HOME OFFICE/CHAIN ORGANIZATIONS			
	SYMBOL[1]	NAME	PERCENT OF OWNERSHIP	NAME	PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5							5
50							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 _____.

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	ADMINISTRA-TIVE & GENERAL	NURSING ADMINISTRA-TION	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

		RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL (ACCUM. COST)	NURSING ADMINISTRA-TION (DIRECT NURS HRS)	RECONCIL-IATION	MEDICAL RECORDS (ACCUM. COST)	OTHER GENERAL SERVICE (SPECIFY)	TOTAL	
		6A	6	7	8A	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	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 PATIENT SERVICES	FROM WKST. B, COL. 10, LINE:	TOTAL COST	TOTAL VISITS	AVERAGE COST PER VISIT	HHA MEDICARE PROGRAM VISITS	HHA MEDICARE PROGRAM COSTS	
		1	2	3	4	5	6	
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 NOT SUBJECT TO DED & COINSUR	HHA SERVICES SUBJECT TO DED & COINSUR	OPPS REIMBURSED SERVICES	HHA SERVICES NOT SUBJECT TO DED & COINSUR	HHA SERVICES SUBJECT TO DED & COINSUR	
			1	2	3	4	5	6	7	8	9	
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

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 (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
29.50	*Late-filed NOA/RAP amount*		*29.50*
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

	DESCRIPTION			DATE 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 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
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	SUBTOTAL (sum of lines 5.01 through 5.49, minus sum of lines 5.50 through 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

	NAME OF CONTRACTOR	CONTRACTOR NUMBER	NPR DATE	
8				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
26.50	Other fixed assets		26.50
27	TOTAL FIXED ASSETS (sum of lines 11 through 26, and 26.50)		27
	OTHER ASSETS		
28	Investments		28
29	Deposits on leases		29
30	Due from owners/officers		30
30.50	Other assets		30.50
31	TOTAL OTHER ASSETS (sum of lines 28 through 30, and 30.50)		31
32	TOTAL ASSETS (sum of lines 10, 27 and 31)		32

	LIABILITIES AND FUND BALANCE (Omit Cents)	AMOUNT	
	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 Wkst. A, line 100, col. 6)			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 *(or loss)* 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
31.50	COVID-19 PHE Funding			31.50
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	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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	RECLASSI-FICATIONS	SUBTOTAL	ADJUST-MENTS	TOTAL	
		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 1	GENERAL SERVICE EXPENSES FROM WKST B 2	TOTAL EXPENSES 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										101
102	Unit cost multiplier										102

COST ALLOCATION - HHA-BASED HOSPICE
STATISTICAL BASES

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											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	COST TO CHARGE RATIO	CHARGES BY LOC				SHARED SERVICE COSTS BY LOC				
						HCHC	HRHC	HIRC	HGIP	HCHC	HRHC	HIRC	HGIP	
		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 10)				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 10)				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 10)				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 10)				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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