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: _____

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically prepared cost report	DATE: _____
	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

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE I CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT, DIRECTLY OR INDIRECTLY, OF A KICKBACK OR W 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 cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Num the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and s are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I fu 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 wer 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 state legally binding equivalent of my original signature.

(Signed) _____
Chief Financial Officer or Adminis

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

1	HOME HEALTH AGENCY	

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

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

PERIOD: FROM: _____ TO: _____	WORKSHEET S PARTS I, II & III

TIME: _____

10. NPR Date:_____
11. Contractor Vendor Code: _____
12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

BY CRIMINAL,
DENTIFIED IN
ERE OTHERWISE

/ submitted
ber(s)} for
statement
rther certify
e provided

ment to be the

trator of Provider (s)

TITLE XVIII	
1	
	1

3 control number.
195 hours per
collection. If you
oulevard,
nedical records or
formation
questions or

IDENTIFICATION DATA | HHA CCN: _____

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		
		1		
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
		1
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

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
		1	2	3	4	5
18	Home Office Information					

DRAFT

PERIOD: FROM: _____ TO: _____	WORKSHEET S-2, PART I	
		1
		2

PROVIDER CCN	DATE CERTIFIED	
2	3	
		3
		4

		5
		6
		7
		8
		9
		10
		11
		12
		13

PAID LOSSES	SELF-INSURANCE	
2	3	
		14
		15

1	2	
		16
		17
STATE	ZIP CODE	
6	7	
		18

DRAFT FORM CMS-1728-20

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	
3	
	1
	2
	3

Date	
3	
	4
	5

Y/N	
	6
	7
	8

Date	
2	
	9
	10
	11
	12
	13
	14

tle	
3	
	15
	16
	17

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

PART I - VISITS DATA

	DESCRIPTION	TITLE XVIII - MEDICARE		TITLE XIX - MEDICAID		OTHER	
		VISITS	PATIENT CENSUS	VISITS	PATIENT CENSUS	VISITS	PATIENT CENSUS
		1	2	3	4	5	6
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)

14	Number of hours in your normal work week		

		STAFF	CONTRACT
		1	2
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

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

DRAFT

WORKSHEET S-3
PARTS I, II, & III

TOTAL		
VISITS	PATIENT CENSUS	
7	8	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14

TOTAL	
3	
	15
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	30
	31
	32
	33

1	
	34
CBSA Codes	
	35

STATISTICAL DATA | HHA CCN: _____

PART IV - PPS ACTIVITY DATA

	DESCRIPTION	FULL EPISODES/ PERIODS WITHOUT OUTLIERS	FULL EPISODES/ PERIODS WITH OUTLIERS	LUPA EIPSODES/ PERIODS
		1	2	3
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			

PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART IV

PEP EIPSODES/ PERIODS	TOTAL EIPSODES/ PERIODS	
4	5	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18

STATISTICAL DATA
DIRECT CARE EXPENDITURES

HHA CCN: _____

	OCCUPATIONAL CATEGORY	AMOUNT REPORTED 1	FRINGE BENEFITS 2	ADJUSTED SALARIES 3
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			

DRAFT

PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART V	
PAID HOURS RELATED TO SALARY	AVERAGE HOURLY WAGE	
4	5	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26

HHA-BASED HOSPICE STATISTICAL DATA	HHA CCN: _____ HOSPICE CCN: _____

PART I - ENROLLMENT DAYS

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

PERIOD: FROM: _____ TO: _____	WORKSHEET S-4 PARTS I & II

ATED DAYS

OTHER	TOTAL	
3	4	
		1
		2
		3
		4
		5

OTHER	TOTAL	
3	4	
		6
		7

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

HHA CCN: _____

			SALARIES	EMPLOYEE BENEFITS	TRANSPOR-TATION	CON-TRACTED PURCHASED SERVICES	OTHER COSTS	TOTAL	RECLASSI-FICATION
			1	2	3	4	5	6	7
		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							

DRAFT

PERIOD: FROM: _____ TO: _____		WORKSHEET A	
RECLASSI- FIED TRIAL BALANCE	ADJUST- MENTS	EXPENSES FOR COST ALLOCATION	
8	9	10	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			16
			17
			18
			19
			20
			21
			22
			23
			24
			25
			26
			27
			28
			29
			30
			39
			40
			41
			42
			43
			44
			45
			46
			47
			48
			49
			50
			57
			58
			100

DRAFT

FORM CMS-1728-20

RECLASSIFICATIONS

HHA CCN: _____

PERIOD:
FROM: _
TO: ____

	EXPLANATION OF RECLASSIFICATION(S)	CODE[1]	INCREASE				DECI	
			COST CENTER	WS A LINE NO.	SALARY[2]	OTHER[2]	COST CENTER	WS A LINE NO.
		1	2	3	4	5	6	7
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
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.

Rev. 1

WORKSHEET A-6

REASE

SALARY[2]	OTHER[2]	
8	9	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		100

ADJUSTMENTS TO EXPENSES

HHA CCN: _____

	DESCRIPTION[1]	BASIS / CODE[2] 1	AMOUNT 2
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)		
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
32			
33			
34			
35			
36			
37			
38			
39			
40			
41			
42			
43			
44			
45			
46			
47			
48			
49			
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

PERIOD: FROM: _____ TO: _____	WORKSHEET A-8	
EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
Cost Center	Line No.	
3	4	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		48
		49
		50

DRAFT

FORM CMS-1728-20

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS
AND HOME OFFICE COSTS

HHA CCN: _____

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
	1	2	3	4	5	6
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 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 FURNIS 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 P 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.

	SYMBOL[1]	NAME	PERCENT OF OWNERSHIP	RELATED ORGANIZATIO NAME
	1	2	3	4
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 _____.

PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-1

AMOUNT INCLUDED IN WKST. A, COL. 8	NET ADJUSTMENTS	
7	8*	
		1
	0	2
	0	3
	0	4
	0	5
		50

SHED
ROVIDE

NS AND/OR HOME OFFICE

PERCENT OF OWNERSHIP	TYPE OF BUSINESS	
5	6	
		1
		2
		3
		4
		5
		50

COST ALLOCATION - GENERAL SERVICE COST | HHA CCN: _____ | PERIOD: FROM _____ TO _____

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

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

DRAFT FORM CMS-1728-16

COST ALLOCATION - STATISTICAL BASIS | HHA CCN: _____ | PERIOD: FROM _____ TO _____

		CAPITAL RELATED COSTS & FIXTURES FEET	CAPITAL RELATED COSTS EQUIPMENT	PLANT MAINTENANCE FEET)	TRANS- (MILEAGE)	IATION	ADMINISTRA- & GENERAL LATED COST)
		1		3	4	5A	5
	GENERAL SERVICE COST CENTER						
1	Capital Related - Bldg. and Fixtures						
2	Capital Related - Movable Equipment						
3	Plant Operation & Maintenance						
4	Transportation (See Instructions)						
5	Administrative and General						
6	Other (specify)						
	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 Pathology						
23	Medical Social Services						
24	Home Health Aide						
25	Medical Supplies (See Instructions)						
26	Drugs						
27	Cost of Administering Vaccines						
28	DME						
29	Disposable Devices						
30	Other (specify)						
	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	Other (specify)						
	SPECIAL PURPOSE COST CENTER						
57	Hospice						
58	Other (specify)						
	Total						
101	Cost To Be Allocated (Per Wkst B)						
102	Unit Cost Multiplier						

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

Rev.

DRAFT

WORKSHEET B

TOTAL	
6	
	1
	2
	3
	4
	5
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	39
	40
	41
	42
	43
	44
	45
	47
	57

Rev.

WORKSHEET B-1

TOTAL	
6	
	1
	2
	3
	4
	5
	6
	16
	17
	18
	19
	20
	21
	22
	23
	24
	25
	26
	27
	28
	29
	39
	40
	41
	42
	43
	44
	45
	46
	47
	57
	58
	100
	101
	102

COST ALLOCATION
ALLOCATION OF GENERAL SERVICE COSTS

HHA CCN: _____

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE	TRANS-PORTATION
			BLDGS & FIXTURES	MOVABLE EQUIPMENT		
		0	1	2	3	4
	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	

PERIOD: FROM: _____ TO: _____	WORKSHEET B	COST ALLOCATION ALLOCATION OF GENERAL SERVICE COSTS					
SUBTOTAL	TELE- COMMUN. TECHNOLOGY				SUBTOTAL	ADMINISTRA- TIVE & GENERAL	NURSING ADMINISTRA- TION
4A	5				5A	6	7
				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	
SUBTOTAL	MEDICAL RECORDS	OTHER GENERAL SERVICE	TOTAL	
7A	8	9	10	
				1
				2
				3
				4
				5
				6
				7
				8
				9
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				39
				40
				41
				42
				43
				44
				45
				46
				47
				48
				49
				50
				57
				58
				100

COST ALLOCATION
STATISTICAL BASES

HHA CCN: _____

	COST CENTER	CAPITAL RELATED COSTS		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	TRANS-PORTATION (MILEAGE)
		BLDGS & & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (DOLLAR VALUE)		
		1	2	3	4
	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				

PERIOD:
FROM: _____
TO: _____

COST ALLOCATION
STATISTICAL BASES

RECONCIL-IATION	TELE-COMMUN. TECHNOLOGY (ACCUM. COST)				RECONCIL-IATION	ADMINISTRA-TIVE & GENERAL (ACCUM. COST)	NURSING ADMINISTRA-TION (DIRECT NURS HRS)
5A	5				6A	6	7
				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	
RECONCIL-IATION	MEDICAL RECORDS (ACCUM. COST)	OTHER GENERAL SERVICE (SPECIFY)	TOTAL	
8A	8	9	10	
				1
				2
				3
				4
				5
				6
				7
				8
				9
				16
				17
				18
				19
				20
				21
				22
				23
				24
				25
				26
				27
				28
				29
				30
				39
				40
				41
				42
				43
				44
				45
				46
				47
				48
				49
				50
				57
				58
				100
				101

APPORTIONMENT OF PATIENT SERVICE COSTS | HHA CCN: _____ | PERIO 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		AVERAG COST PER VISI
			COST	VISITS	
		1	2	3	4
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	HHA SERVICES		OPPS REIMBURS SERVICE
							NOT SUBJECT TO DED & COINSUR	SUBJECT TO DED & COINSUR	
			1	2	3	4	5	6	7
11	Cost of Medical Supplies	25							
12	Cost of Drugs	26							
13	Cost of Administering Vaccines	27							
14	Disposable Devices	29							

D: : _____ _____	WORKSHEET C PARTS I & II	

E T	HHA MEDICARE PROGRAM VISITS	HHA MEDICARE PROGRAM COSTS	
	5	6	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10

	COST OF MEDICARE SERVICES		
	HHA SERVICES		
SED S	NOT SUBJECT TO DED & COINSUR	SUBJECT TO DED & COINSUR	
	8	9	
			11
			12
			13
			14

CALCULATION OF REIMBURSEMENT SETTLEMENT	HHA CCN:

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

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

PERIOD: FROM: _____ TO: _____	WORKSHEET D

NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
1	2	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39

ANALYSIS OF PAYMENTS TO HHA FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	HHA CCN: _____	PERIOD: FROM: _____ TO: _____

	DESRIPTION			DATE 1
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
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.

WORKSHEET D-1

AMOUNT	
2	
	1
	2
	3.01
	3.02
	3.03
	3.04
	3.05
	3.50
	3.51
	3.52
	3.53
	3.54
	3.99
	4

	5.01
	5.02
	5.03
	5.50
	5.51
	5.52
	5.99
	6.01
	6.02
	7
NPR DATE	8

BALANCE SHEET | HHA CCN: _____

	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)

PERIOD: FROM: _____ TO: _____	WORKSHEET F	
	AMOUNT	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26
		27
		28
		29
		30
		31
		32
	AMOUNT	
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		48

STATEMENT OF REVENUES AND EXPENSES	HHA CCN:

		TITLE XVIII MEDICARE	TITLE XIX MEDICAID
		1	2
1	Gross patient revenues		
2	Less: Allowances and discounts on patients' accounts		
3	Net patient revenues (line 1 minus line 2)		
4	Operating expenses (from Wkst. A, line 100, col. 6)		
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
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)		

PERIOD: FROM: _____ TO: _____	WORKSHEET F-1	
OTHER	TOTAL	
3	4	
		1
		2
		3
1	2	
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23
		24
		25
		26
		27
		28
		29
		30
		31
		32
		33

DRAFT

FORM CMS 1728-20

ANALYSIS OF HHA-BASED HOSPICE COSTS

HHA CCN: _____

HOSPICE CCN: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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.

PERIOD: FROM: _____ TO: _____	WORKSHEET O	
ADJUST- MENTS	TOTAL	
6	7	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39

PERIOD: FROM: _____ TO: _____	WORKSHEET O	
ADJUST- MENTS	TOTAL	
6	7	
		40
		41
		42
		43
		44
		45
		46
		47
		60
		61
		62
		63
		64
		65
		66
		67
		68
		69
		70
		71
		100

ANALYSIS OF HHA-BASED HOSPICE COSTS
CONTINUOUS HOME CARE

HHA CCN: _____

HOSPICE CCN: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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.

PERIOD: FROM: _____ TO: _____	WORKSHEET O-1	
ADJUST- MENTS	TOTAL	
6	7	
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		100

ANALYSIS OF HHA-BASED HOSPICE COST
ROUTINE HOME CARE

HHA CCN: _____

HOSPICE CCN: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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

PERIOD: FROM: _____ TO: _____	WORKSHEET O-2	
ADJUST- MENTS	TOTAL	
6	7	
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		100

DRAFT

FORM CMS 1728-20

ANALYSIS OF HHA-BASED HOSPICE COSTS
INPATIENT RESPITE CARE

HHA CCN: _____

HOSPICE CCN: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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

PERIOD: FROM: _____ TO: _____	WORKSHEET O-3	
ADJUST- MENTS	TOTAL	
6	7	
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		100

ANALYSIS OF HHA-BASED HOSPICE COSTS
GENERAL INPATIENT CARE

HHA CCN: _____

HOSPICE CCN: _____

		SALARIES	OTHER	SUBTOTAL	RECLASSI-FICATIONS	SUBTOTAL
		1	2	3	4	5
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

PERIOD: FROM: _____ TO: _____	WORKSHEET O-4	
ADJUST- MENTS	TOTAL	
6	7	
		25
		26
		27
		28
		29
		30
		31
		32
		33
		34
		35
		36
		37
		38
		39
		40
		41
		42
		43
		44
		45
		46
		47
		100

DETERMINATION OF HHA-BASED HOSPICE TOTAL EXPENSES FOR ALLOCATION

HHA CCN: _____

HOSPICE CCN: _____

	Descriptions	HOSPICE DIRECT EXPENSES
		1
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	

PERIOD: FROM: _____ TO: _____	WORKSHEET O-5	
GENERAL SERVICE EXPENSES FROM WKST B	TOTAL EXPENSES	
2	3	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		50
		51
		52
		53
		60
		61
		62
		63
		64
		65
		66
		67
		68
		69
		70
		71
		99
		100

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

HHA CCN: _____
HOSPICE CCN: _____

PERIO
FROM
TO: __

		TOTAL EXPENSES	CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	PLANT OP & MAINT	LAUNDR & LINEN
		0	1	2	3	3A	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								
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								

DRAFT

FORM CMS-1728-20

COST ALLOCATION - HHA-BASED HOSPICE GENERAL SERVICE COSTS

HHA CCN: _____

HOSPICE CCN: _____

PERIO
FROM
TO: __

	Descriptions	NURSING ADMINIS-TRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANS-PORTATION	VOLUNTEER SVC COOR-DINATION	PHARMACY	PHYSICIAN ADMINISTRA-TIVE SVCS	OTHER GENERA SERVICI
		9	10	11	12	13	14	15	16
	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								

D:
: _____
_____

WORKSHEET O-6
PART I

Y N	HOUSE- KEEPING	DIETARY	
	7	8	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			17
			50
			51
			52
			53
			60
			61
			62
			63
			64
			65
			66
			67
			68
			69
			70
			71
			99
			100

D:
: _____
_____

WORKSHEET O-6
PART I

L E	PATIENT / RESIDENTIAL CARE SVCS	TOTAL	
	17	18	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			17
			50
			51
			52
			53
			60
			61
			62
			63
			64
			65
			66
			67
			68
			69
			70
			71
			99
			100

COST ALLOCATION - HHA-BASED HOSPICE
STATISTICAL BASES

HHA CCN: _____

HOSPICE CCN: _____

PERIO
FROM
TO: __

	Cost Center Descriptions	CAP REL BLDG & FIX (SQUARE FEET) 1	CAP REL MVBLE EQUIP (DOLLAR VALUE) 2	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES) 3	RECONCIL-IATION 4A	ADMINIS-TRATIVE & GENERAL (ACCUM. COST) 4	PLANT OP & MAINT (SQUARE FEET) 5	LAUNDR & LINEN (IN-FACI ITY DAY 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							
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							
101	Cost to be allocated							
102	Unit cost multiplier							

DRAFT

FORM CMS-1728-20

COST ALLOCATION - HHA-BASED HOSPICE
STATISTICAL BASES

HHA CCN:

HOSPICE CCN:

PERIO
FROM:
TO: __

	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 GENERA SERVICI (SPECIF BASIS)
		9	10	11	12	13	14	15	16
	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								
101	Cost to be allocated								
102	Unit cost multiplier								

D:
: _____
_____

WORKSHEET O-6
PART II

.Y ɴ L- S)	HOUSE- KEEPING (SQUARE FEET)	DIETARY (IN-FACIL- ITY DAYS)	
	7	8	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			17
			50
			51
			52
			53
			60
			61
			62
			63
			64
			65
			66
			67
			68
			69
			70
			71
			99
			101
			102

D: : _____ _____		WORKSHEET O-6 PART II	
L E Y	PATIENT / RESIDENTIAL CARE SVCS (IN-FACIL-ITY DAYS)	TOTAL	
	17	18	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10
			11
			12
			13
			14
			15
			16
			17
			50
			51
			52
			53
			60
			61
			62
			63
			64
			65
			66
			67
			68
			69
			70
			71
			99
			101
			102

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

HHA CCN: _____

HOSPICE CCN: _____

PERIOD
FROM:
TO: ___

	Cost Center Descriptions	WKST. B, COL. 10, LINE	TOTAL HHA COSTS	TOTAL HHA CHARGES	COST TO CHARGE RATIO	CHARGES BY LOC				S
						HCHC	HRHC	HIRC	HGIP	HCHC
		0	1	2	3	4	5	6	7	8
	ANCILLARY SERVICE COST CENTERS									
1	Physical Therapy	18								
2	Physical Therapy Assistant	19								
3	Occupational Therapy	20								
4	Certified Occupational Therapy Assistant	21								
5	Speech-Language Pathology	22								
6	Medical Social Services	23								
7	Medical Supplies (see instructions)	25								
8	Drugs	26								
9	Durable Medical Equipment/Oxygen	28								
10	Totals (sum of lines 1-9)									

D:

WORKSHEET O-7

SHARED SERVICE COSTS BY LOC

HRHC	HIRC	HGIP	
9	10	11	
			1
			2
			3
			4
			5
			6
			7
			8
			9
			10

CALCULATION OF HHA-BASED HOSPICE PER DIEM COST	HHA CCN: _____ HOSPICE CCN: _____

		TITLE XVIII MEDICARE
		1
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)	

This page intentionally left blank.

PERIOD: FROM: _____ TO: _____	WORKSHEET O-8	
TITLE XIX MEDICAID	TOTAL	
2	3	
		1
		2
		3
		4
		5
		6
		7
		8
		9
		10
		11
		12
		13
		14
		15
		16
		17
		18
		19
		20
		21
		22
		23