



General Instructions

General Instructions for completing Appendix C: Home Health Cost Data Form (Freestanding) and Appendix D: Home Health Cost Data Form (Hospital-Based) included in Part II Policies and Procedures for Home Health Services Manual. Complete the appropriate appendix depending on the status of the home health organization. The completed appendix must be included with the electronically filed cost report pursuant with Section 1001.1 Cost Report.

1. Freestanding (Appendix C)

- a. Complete heading to include Provider Name, Medicaid Provider Number and Cost Reporting Period being filed.
- b. Section I
 - i. Column (1) - Enter total of visits for Medicaid per each discipline listed from agency's record.
 - ii. Column (2) - Enter the Agency's total of visits per each discipline recorded on CMS Form 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 3, Lines 1-9.
 - iii. Enter total of each column on Total line.
- c. Section II- Enter cost total for each discipline from CMS Form 1728, Worksheet C, Cost per Visit Computational, Part I, Column 2, Lines 1-9.
- d. Section III-
 - i. Line (1)-Enter Agency's total cost of medical supplies from CMS Form 1728 Worksheet C, Part III Other Patient Services, Line 15, Column 2.
 - ii. Line (2) - Enter Total Charges to all Patients from CMS Form 1728 Worksheet C, Part III Other Patient Services, Line 15, Column 3.
 - iii. Line (3)- Enter Ratio of Cost to Charges from CMS Form 1728 Worksheet C, Part III Other Patient Services, Line 15, Column 4.
 - iv. Line (4) - Enter Medicaid Charges amount from agency's records.
 - v. Line (5) - Enter Medicaid Cost: Multiply Line (3) and Line (4).
- e. Signature of Officer or Administrator: include title and date of completion.



General Instructions

2. Hospital- Based (Appendix D)

- a. Complete heading to include Provider Name, Medicaid Provider Number and Cost Reporting Period being filed.
- b. Section I
 - i. Column (1) - Enter total of visits for Medicaid per each discipline listed from agency's record.
 - ii. Column (2) - Enter the Agency's total of visits per each discipline recorded on CMS Form 2552, Worksheet H-6, Part I, Column 4, Lines 1, 2, 3, 4, 5 and 6.
 - iii. Enter total of each column on Total line.
- c. Section II- Enter cost total for each discipline from CMS Form 2552, Worksheet H-6, Part I, Column 3, Lines 1, 2, 3, 4, 5, and 6.
- d. Section III-
 - i. Line (1)-Enter Agency's total cost of medical supplies from CMS Form 2552 Worksheet H-6, Part I Other Patient Services, Line 15, Column 2.
 - ii. Line (2) - Enter Total Charges to all Patients from CMS Form 2552 Worksheet H-6, Part I Other Patient Services, Line 15, Column 3.
 - iii. Line (3)- Enter Ratio of Cost to Charges from CMS Form 2552 Worksheet H-6, Part I Other Patient Services, Line 15, Column 4.
 - iv. Line (4) - Enter Medicaid Charges amount from agency's records.
 - v. Line (5) - Enter Medicaid Cost: Multiply Line (3) and Line (4).
- e. Signature of Officer or Administrator: include title and date of completion.

A step-by-step example of how to complete the Cost Data Form correctly is provided on pages 3-5.



Cost Data Form Example

A. The Cost Report is the source document for the Cost Data Form (Appendices C and D). Complete Steps 1 thru 4 below.

1. Input **Total Visits** from Column 4.00 of the Cost Report into Column (2) in **Part I** of the Cost Data Form. Review the numbers in yellow highlights in both screenshots below:

Health Financial Systems		XXXXXX HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: XX-XXXX		Period: From 07/01/2022 To 06/30/2023		Worksheet H-3 Part I Date/Time Prepared: XX/XX/2023 XX:XX am	
		Title XVIII		Home Health Agency I		PPS	
Cost Center Description	From, wkst. H-2, Part I, col. 28, line	Facility Costs (from wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,111,111		1,111,111	7,777	142.87
2.00	Physical Therapy	3.00	222,222	0	222,222	4,444	50.00
3.00	Occupational Therapy	4.00	120,664	0	111,111	999	111.22
4.00	Speech Pathology	5.00	22,222	0	22,222	111	200.19
5.00	Medical Social Services	6.00	0		0	1	0.00
6.00	Home Health Aide	7.00	3,333		3,333	66	50.50
7.00	Total (sum of lines 1-6)		1,469,999	0	1,469,999	13,398	7.00

**APPENDIX D
HOME HEALTH COST DATA FORM (HOSPITAL-BASED)**

PROVIDER NAME: XXXXXXXXX Hospital
 MEDICAID PROVIDER NUMBER: 00000000A
 COST REPORTING PERIOD - FROM: 7/1/2022 TO: 6/30/2023

I. VISITS BY DISCIPLINE	(1)	(2)
	Medicaid Home Health	Agency Total Home Health
Skilled Nursing	1,111	7,777
Physical Therapy	444	4,444
Occupational Therapy	111	999
Speech-Language Pathology	22	111
Medical Social Services		1
Home Health Aide Services	3	66
Total	1,691	13,398

(1) Enter information from agency's records.
 (2) Enter information from CMS Form 2552, Worksheet H-3, Part I, Column 4, Lines 1-6.



Cost Data Form Example

2. Input **Agency Total Costs** from Column 3.00 of the Cost Report into Column (2) in **Part II** of the Cost Data Form. Review the numbers in yellow highlights in both screenshots below:

Health Financial Systems		XXXXXX HOSPITAL, INC.			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: XX-XXXX		Period: From 07/01/2022 To 06/30/2023		Worksheet H-3 Part I Date/Time Prepared: XX/XX/2023 XX:XX am	
		HHA CCN: XX-XXXX		Title XVIII		Home Health Agency I PPS	
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,111,111		1,111,111	7,777	142.87
2.00	Physical Therapy	3.00	222,222	0	222,222	4,444	50.00
3.00	Occupational Therapy	4.00	120,664	0	111,111	999	111.22
4.00	Speech Pathology	5.00	22,222	0	22,222	111	200.19
5.00	Medical Social Services	6.00	0		0	1	0.00
6.00	Home Health Aide	7.00	3,333		3,333	66	50.50
7.00	Total (sum of lines 1-6)		1,469,999	0	1,469,999	13,398	7.00

II. COST INFORMATION

	(1) Agency Total Home Health
Skilled Nursing - RN	1,111,111
Physical Therapy	222,222
Occupational Therapy	111,111
Speech-Language Pathology	22,222
Medical Social Services	-
Home Health Aide Services	3,333
Total	1,469,999

Enter information from CMS Form 2552, Worksheet H-3, Part I, Column 3, Lines 1-6.



Cost Data Form Example

3. Input **Agency HHA Costs** (Column 3.00) and **Total Charges** (Column 4.00) of the Cost Report into Lines (1) and (2) in **Part III** of the Cost Data Form. After both **Agency HHA Costs** and **Total Charges** are entered into the form, the RCC will automatically calculate for Line (3). Also, input Medicaid Charges from your agency's records into Line (4) then the Medicaid Cost on Line (5) will automatically calculate. Review the numbers in yellow highlights in both screenshots below:

Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	50,199	0	44,444	233,333	0.190474
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000

III. MEDICAL SUPPLIES BILLED TO PATIENTS			
(1) Total Agency Cost	44,444	(4) Medicaid Charges	1,111
(2) Total Charges	233,333	(5) Medicaid Cost	212
(3) Ratio of Cost to Charges (RCC)	0.1905	(RCC x Medicaid Charges)	

(1) (2) (3) Enter information from CMS Form 2552 Worksheet H-3, Part I, Line 15, Columns 2, 3, and 4, respectively.
 (4) Enter information from agency's records.

4. Add signature, title, and date to the bottom of the Cost Data Form. Review the screenshot below.

Jane Doe

 Officer or Administrator of Agency

CFO

 Title

XX/XX/2024

 Date