GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HOME HEALTH CARE SERVICES

HOME OFFICE COST DATA FORM

FOR THE PERIOD _____ THROUGH _____

NAME: _____ ADDRESS: _____

TELEPHONE: _____ _____

PURPOSE

The purpose of this form is to provide summary cost information from the Medicare Home Office Cost Statement (Form HCFA-287) for the home office, each Georgia home health care agency and any other component(s) of the home office organization.

INSTRUCTIONS

Columns 1 and 2, lines 1-7, should list all Georgia home health care agencies receiving services from the home office organization and the related Medicaid provider numbers. Column 3, lines 1-7 should report the total home office costs allocated to the Georgia home health care agencies. The amount to place on each line is the sum of the direct allocations (Schedule E), functional allocations (Schedule F), and pooled allocations (Schedule H), for each Georgia home health care agency as reported in the Medicare Home Office Cost Statement. These amounts should agree with the amounts shown as home office costs on each provider cost report unless the home office and the home health care agencies have nonconcurrent year ends. Line 8 should report the sum of the direct, functional and pooled allocations for all other components of the chain organization. The sum of Column 3, lines 1-8, should equal the total home office allowable expenses reported on Schedule B, column 3, line 25, of the Medicare Home Office Cost Statement.

| GEORGIA HOME HEALTH CARE AGENCIES | MEDICAID # | TOTAL HOME OFFICE COST ALLOCATED TO COMPONENTS |
|---|---|---|
| 1._____ | _____ | _____ |
| 2._____ | _____ | _____ |
| 3._____ | _____ | _____ |
| 4._____ | _____ | _____ |
| 5._____ | _____ | _____ |
| 6._____ | _____ | _____ |
| 7._____ | _____ | _____ |
| 8. OTHER COMPONENT (S) | | _____ |
| TOTAL HOME OFFICE ALLOWABLE COSTS | | ========== |

CERTIFICATION

I hereby certify that I have attached a complete and accurate copy of the Medicare Home Office Cost Statement (Form HCFA-287 or equivalent) filed with the Medicare Intermediary and will forward a copy of the final settled cost report to the Department of Community Health as soon as it is settled. I understand that this cost data form and its attachments are subject to audit by the Department or its agents.

SIGNATURE: _____ DATE: _____

NAME: _____ TITLE: _____