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

PROVIDER NAME: ______________________________

MEDICAID PROVIDER NUMBER: ______________________________

COST REPORTING PERIOD - FROM: ______________ TO: ______________

I. VISITS BY DISCIPLINE

	(1) Medicaid Home Health	(2) Agency Total Home Health
Skilled Nursing		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Home Health Aide		
Total		

(1) Enter information from agency's records.

(2) Enter information from CMS Form 2552, Worksheet H-6, Part I, Column 4, Lines 1, 2, 3, 4, 5, and 6.

II. COST INFORMATION

	(1) Agency Total Home Health
Skilled Nursing	
Physical Therapy	
Speech Therapy	
Occupational Therapy	
Home Health Aide	
Total	

Enter information from CMS Form 2552, Worksheet H-6, Part I, Column 3, Lines 1, 2, 3, 4, 5, and 6.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

(1) Total Agency Cost ______________

(2) Total Charges ______________

(3) Ratio of Cost to Charges (RCC) ______________

(4) Medicaid Charges ______________

(5) Medicaid Cost ______________
(RCC x Medicaid Charges)

(1) (2) (3) Enter information from CMS Form 2552 Worksheet H-6, Part I Other Patient Services, Line 15, Columns 2, 3, and 4, respectively.
(4) Enter information from agency's records.

(Signed) ______________________________
Officer or Administrator of Agency

____
Title

____
Date

DMA-600-HB (9/95)