**APPENDIX C**
**HOME HEALTH COST DATA FORM (FREESTANDING)**

**PROVIDER NAME:** _____

**MEDICAID PROVIDER NUMBER:** _____

**COST REPORTING PERIOD - FROM:** _____ **TO:** _____

| I. VISITS BY DISCIPLINE | (1) Medicaid Home Health | (2) Agency Total |
|---|---|---|
| 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 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 3, 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 1728, Worksheet C, Cost Per Visit Computational, Part I, Column 2, Lines 1, 2, 3, 4, 5, and 6.

III. MEDICAL SUPPLIES BILLED TO PATIENTS

| | | | |
|---|---|---|---|
| (1) Total Agency Cost | | (4) Medicaid Charges | |
| (2) Total Charges | | (5) Medicaid Cost (RCC x Medicaid Charges) | |
| (3) Ratio of Cost to Charges (RCC) | | | |

(1) (2) (3) Enter information from CMS Form 1728 Worksheet C, Part III 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-601-FS (9/95)