HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT

For Period Beginning _____

And Period Ending _____

_____

Name Of Provider

_____

Home Health Provider Number

_____

HCB Provider Number

Address Of Provider

_____

_____

_____

_____

HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT

SCHEDULE A
STATISTICAL DATA

Provider Name: Home Health Number: HCB Number:

Period Covered by Statement: From: To:

STATISTICS

	Total Unit/Visits	XIX Unit/Visits
	1	2
HOME HEALTH		
1. Skilled Nursing		-
2. Physical Therapy		-
3. Speech Therapy		-
4. Occupational Therapy		-
5. Medical Social Services		-
6. Home Health Aide		-
HCB		
7. Client Assessment/Reassessment		-
8. Case Management		-
9. Homemaker		-
10. Personal Care		-

	Total Charges	XIX Charges	XIX % of Charges
11. Respite Care			
12. Home Adaptation			

HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT
SCHEDULE B

ADJUSTMENT AND RECLASSIFICATION OF EXPENSES

Provider Name:

Home Health Number:
HCB Number:

Period Ending:

	1	2	3	4	5	6
	Salaries	Other	TOTAL	Adjust-Ment	Reclassi-Fication	TOTAL
General Services:						
1. Equipment Depreciation						
2. Vehicle Depreciation						
3. Building Depreciaton						
4. Operation Of Plant						
5. Transportation						
6. Housekeeping						
7. Employee Health & Welfare						
8. Administrative & General						
9. Director's Salary						
10. Property Taxes						
11. Insurance-Plant & Equipment						
12. Insurance-Other						
13. Insurance-Vehicle						
14. Interest-Plant & Equipment						
15. Interest-Other						
16. Other-Provider Tax						
Direct Services: (Home Health Program)						
17. Medical Supplies						
18. Skilled Nursing						
19. Physical Therapy						
20. Speech Therapy						
21. Occupational Therapy						
22. Medical Social Therapy						
23. Home Health Aides						
Direct Services: (HCB Program)						
24. Client Assessment/Reassessment						
25. Case Management						
26. Homemaker						
27. Personal Care						
28. Respite Care						
29. Home Adaptation						
Direct Services: Other Nonreimburseable						
30. Private Duty Nursing						
31. Home Infusion						
32. Other:						
33. Other:						
34. Other:						
35. Other:						
Non-Reimbursable Title XIX:						
36. Attendant Care						
37. Model Waiver #2 (16HR)						
38. Durable Medical Equipment						
39. Other:						
40. **TOTAL**						

HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT
SCHEDULE B-1
ADJUSTMENTS TO EXPENSE

Provider Name: Period Ending:

Home Health Number:
HCB Number:

(1) Description	(2) A/B	(3) INC/<DEC>	(4) Line #
1. Trade, Quantity, Time and Other Discounts On Purchases			
2. Rebates And Refunds Of Expenses			
3. Home Office Costs			
4. Adjustments Resulting From Transactions With Related Organizations	A		8
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. Physical Therapy Adjustment			19
10. Interest Expense On Medicaid Overpayments And Borrowings To Repay Medicaid Overpayments			
11. Offset of Investment Income			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
Total (To Schedule B Line 40, Column 4).			

Column 2, (A) Cost (B) Revenue

HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT
SCHEDULE B-2

RECLASSIFICATION TO EXPENSE

Provider Name: Period Ending:

Home Health Number:

HCB Number:

(1) Description	(2) Line #	(3) Increase	(4) <Decrease>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
33.			
34. TOTAL			

HEALTH DEPARTME HOME HEALTH
ANNUAL COST REPORT
SCHEDULE C

COST ALLOCATION STATISTICS

Provider Name:

Home Health Number:

HCB Number:

Period Ending:

		(1) Square Footage	(2) Mileage	(3) Salaries	(4) Accumulated Costs
	Direct Services - Home Health				
17.	Medical Supplies				
18.	Skilled Nursing				
19.	Physical Therapy				
20.	Speech Therapy				
21.	Occupational Therapy				
22.	Medical Social Service				
23.	Home Health Aide				
	Direct Services - HCB				
24.	Client Assessment/Reassessment				
25.	Case Management				
26.	Homemaker				
27.	Personal Care				
28.	Respite Care				
29.	Home Adaptation				
	Direct Services: Other Nonreimburseable				
30.	Private Duty Nursing				
31.	Home Infusion				
32.	Other:				
33.	Other:				
34.	Other:				
35.	Other:				
	Non-Reimbursable Title XIX:				
36.	Attendant Care				
37.	MD Waiver #2 (16HR)				
38.	Durable Medical Equipment				
39.	Other:				
40.	**TOTAL**				
41.	**TOTAL TO ALLOCATE**				
42.	**UNIT COST MULTIPLIER**				

HEALTH DEPARTME HOME HEALTH
ANNUAL COST REPORT
SCHEDULE C-1

COST ALLOCATION

Provider Name: Home Health Number: Period Ending:
HCB Number:

		Direct Expense 1	Depr. Bldg. & Equip. Property Taxes, Ins. Plant & Equipment 2	Vehicle Depr. Trans. Vehicle Ins. 3	Employee Health & Welfare 4	Sub Total 5	All Other General Services Costs 6	Total Costs 7
	Direct Services - HHA							
17.	Medical Supplies							
18.	Skilled Nursing							
19.	Physical Therapy							
20.	Speech Therapy							
21.	Occupational Therapy							
22.	Medical Social Services							
23.	Home Health Aides							
	Direct Services - HCB							
24.	Client Assessment/Reassessment							
25.	Case Management							
26.	Homemaker							
27.	Personal Care							
28.	Respite Care							
29.	Home Adaptation							
	Direct Services: Other Nonreimburseable							
30.	Private Duty Nursing							
31.	Home Infusion							
32.	Other:							
33.	Other:							
34.	Other:							
35.	Other:							
	Non-Reimbursable Title XIX:							
36.	Attendant Care							
37.	MD Waiver #2 (16HR)							
38.	Durable Medical Equipment							
39.	Other:							
40	**TOTALS**							

HEALTH DEPARTME HOME HEALTH
ANNUAL COST REPORT
SCHEDULE D
APPORTIONMENT OF PATIENT SERVICE COSTS

Vendor Name: Period Ending:

Home Health Number:

Part I:

Patient Services	Amounts (Sch C-1, Col 7)	Total Units/Visits	Average Cost per Unit/Visit	XIX Program Unit/Visits	Average Cost
1	2	3	4	5	6
1. Skilled Nursing					
2. Physical Therapy					
3. Speech Therapy					
4. Occupational Therapy					
5. Medical Social Services					
6. Home Health Aid Services					
7. Total (Sum of Lines 1- 6)			XXXXXXXXX		

Part II:

Medical Supplies Computation

	Total Cost	Total Charge	Ratio	XIX Charge	XIX Cost
	1	2	3	4	5
1. Medical Supplies					

Part III:

1. **Total Cost of Title XIX Services (Line 7, Col 6, Part I + Line 1, Col 6, Part II)**

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HEALTH DEPARTMENT HOME HEALTH
ANNUAL COST REPORT
SCHEDULE D-1

CALCULATION OF HOME HEALTH REIMBURSEMENT SETTLEMENT

Vendor Name: Period Ending:

Home Health Number:

Part I - Computation Of Reimbursement Settlement

1.	Total Title XIX Cost	
2.	Amounts Rec'd From TPL/Other Sources (PCL's)	
3.	Amounts Rec'd From The Medicaid Program (PCL's)	
4.	Total Interim Payments (Line 2 plus 3)	
5.	Balance Due Provider/Medicaid Program (Line 1 minus 4) (Indicate Overpayments In Parentheses)	

HEALTH DEPARTMENT HOME HEALTH
ANNUAL REPORT
SCHEDULE E
APPORTIONMENT OF PATIENT SERVICE COSTS

Provider Name: HCB Provider Number: Period Ending:

Part I: Patient Services		Amounts (Sch C-1, Col 7)	Total Units/Visits	Average Cost per Unit/Visit	XIX Program Unit/Visits	Average Cost
1		2	3	4	5	6
1.	Client Assessment					
2.	Case Management					
3.	Homemaker					
4.	Personal Care					
5.	TOTAL (Sum of Lines 1 - 4)			xxxxxxxxx		

Part II: Respite and Minor Home Adaptation Costs		(Sch C-1, Col 7)	Title XIX % of Charges	Title XIX Costs
1		2	3	4
1.	Respite Care Services			
2.	Minor Home Adaptation			

Part III: Calculation Of Reimbursement Settlement

1		5	6
1.	Total Medicaid Reimbursable Cost (Part I, Column 6, Line 5 + Part II, Column 4, Lines 1 + 2)		
2.	Amount Received From Medicaid For Waiver Program Services (PCLs)		xxxxxxxxxx
3.	Continuing Income Or TPL (PCLs)		xxxxxxxxxx
4.	Balance Due (Program)/Provider (Line 1 minus Lines 2 and 3)		

HEALTH DEPARTMENT HOME HEALTH

HOME HEALTH AGENCY

SCHEDULE F

Provider Name: Period Ending:

Vendor Number:

A. Statement Of Costs Of Services From Related Organizations

1. In the amount at costs to be reimbursed by the KMAP Program, are any costs included which are a result of transactions with any related organizations?

☐ YES ☐ NO

2.

Schedule	Line No	Item	Amount

B. Certification By Officer Or Director Of The Agency

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF AGENCY

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES, AND OR IMPRISONMENT MAY RESULT.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying electronically "led or manually submitted Home Health Agency Cost Report(s) for the cost reporting period beginning _____ and ending _____, prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(signed) _____

Date: _____