ANNUAL COST REPORT

HOME HEALTH / HCB

FOR PERIOD BEGINNING_____

AND PERIOD ENDING _____

_____

NAME OF FACILITY

_____

VENDOR NUMBER

ADDRESS OF FACILITY

_____

_____

_____

_____

ANNUAL COST REPORT
HOME HEALTH & COMMUNITY BASED SERVICES
SCHEDULE A
STATISTICAL AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

PERIOD COVERED BY STATEMENT: FROM: _____ TO: _____

TYPE OF CONTROL

1. VOLUNTARY NON-PROFIT:

CHURCH _____

OTHER-SPECIFY _____

_____

2. PROPRIETARY:

INDIVIDUAL _____

PARTNERSHIP _____

CORPORATION _____

3. GOVERNMENT:

STATE _____

COUNTY _____

CITY _____

HEALTH DEPT. _____

STATISTICS

		TOTAL UNIT/VISITS 1	XIX UNIT/VISITS 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		
11.	RESPITE CARE		
12.	HOME ADAPTATION		
	HCB EXTENDED AREA		
13.	CLIENT ASSESSMENT/REASSESSMENT		
14.	CASE MANAGEMENT		
15.	HOMEMAKER		
16.	PERSONAL CARE		
17.	RESPITE CARE		
18.	HOME ADAPTATION		

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

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

(1)	(2)	(3)	(4)
DESCRIPTION	A/B	INC / <DEC>	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			
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			
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

HOME HEALTH AGENCY
SCHEDULE B-1a

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART I – GENERAL INFORMATION

1.	Total number of weeks worked (During which outside suppliers (excluding aides) worked)	
2.	Line 1 multiplied by 15 hours per week	
3.	Number of unduplicated HHA visits – Supervisors or therapists (See Instructions)	
4.	Number of unduplicated HHA visits – Therapy assistants (Include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit) (See Instructions)	
5.	Standard travel expense rate	
6.	Optional travel expense rate per mile	

		Supervisors 1	Therapists 2	Assistants 3	Aides 4
7.	Total hours worked				
8.	AHSEA (See Instructions)				
9.	Standard travel allowance (Cols 1 and 2, one-half of col 2, line 8; col 3, one-half of col 3, line 8)				xxxxxxxxxxxx
10.	Number of travel hours (HHA only)				xxxxxxxxxxxx
11.	Number of miles driven (HHA only)				xxxxxxxxxxxx

PART II – SALARY EQUIVALENCY COMPUTATION

12.	Supervisors (Col 1, line 7 times col 1, line 8)	
13.	Therapists (Col 2, line 7 times col 2, line 8)	
14.	Assistants (Col 3, line 7 times col 3, line 8)	
15.	Subtotal Allowance Amount (Sum of lines 12–14)	
16.	Aides (Col 4, line 7 times col 4, line 8)	
17.	Total Allowance Amount (Sum of lines 15 and 16)	
	If the sum of cols 1–3, line 7, is greater than line 2, make no entries on lines 18 and 19 and enter on line 20 the amount from line 17. Otherwise, complete lines 18–20.	
18.	Weighted average rate excluding aides (Line 15 divided by the sum of cols 1–3, line 7)	
19.	Weighted allowance excluding aides (Line 2 times line 18)	
20.	Total Salary Equivalency (Line 17 or sum of lines 16 plus 19)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-1b

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART III – STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION – PROVIDER SITE
Standard Travel Allowance

21.	Therapists (Line 3 times column 2, line 9)	
22.	Assistants (Line 4 times column 3, line 9)	
23.	Subtotal (Sum of lines 21 and 22)	
24.	Standard Travel Expense (Line 5 times sum of lines 3 and 4)	
25.	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site (Sum of lines 23 and 24)	

PART IV – STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION – HHA SERVICES OUTSIDE PROVIDER SITE
Standard Travel Expense

26.	Therapists (Line 3 times col 2, line 9)	
27.	Assistants (Line 4 times col 3, line 9)	
28.	Subtotal (Sum of lines 26 and 27)	
29.	Standard Travel Expense (Line 5 times sum of lines 3 and 4)	

Optional Travel Allowance and Optional Travel Expense

30.	Therapists (Sum of cols 1 and 2, line 10 times col 2, line 8)	
31.	Assistants (Col 3, line 10 times Col. 3, line 8)	
32.	Subtotal (Sum of lines 30 and 31)	
33.	Optional Travel Expense (Line 6 times sum of cols 1–3, line 11)	

Total Travel Allowance and Travel Expense – HHA Services; Complete one of the following three lines 34, 35 or 36, as appropriate.

34.	Standard Travel Allowance and Standard Travel Expense (Sum of lines 28 and 29 – See Instructions)	
35.	Optional Travel Allowance and Standard Travel Expense (Sum of lines 32 and 29 – See Instructions)	
36.	Optional Travel Allowance and Optional Travel Expense (Sum of lines 32 and 33 – See Instructions)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-1c

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART V – OVERTIME COMPUTATION

	DESCRIPTION	THERAPISTS 1	ASSISTANTS 2	AIDES 3	TOTAL 4
37.	Overtime hours worked during cost reporting period (If col 4, line 37, is zero or equal to or greater than 2,080, do not complete lines 38–45 and enter zero in each column of line 46)				
38.	Overtime rate (Multiply the amounts in cols 2–4, line 8 (AHSEA) times 1.5)				
39.	Total overtime (Including base and overtime allowance) (Multiply line 37 by line 38)				
Calculation of Limit:					
40.	Percentage of overtime hours by category (Divide the hours in each column on line 37 by the total overtime worked – col. 4, line 37)				
41.	Allocation of provider's standard workyear for one full-time employee times the percentages on line 40 (See Instructions)				
Determination of Overtime Allowance:					
42.	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols 2–4, line 8)				
43.	Overtime cost limitation (Line 41 times line 42)				
44.	Maximum overtime cost (Enter the lesser of line 39 or line 43)				
45.	Portion of overtime already included in hourly computation at the AHSEA (Multiply line 37 by line 42)				
46.	Overtime allowance (Line 44 minus line 45 – If negative enter zero) (Col 4, sum of cols 1–3)				

PART VI – COMPUTATION OF PHYSICAL THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

47.	Salary equivalency amount (from Part II, line 20)	
48.	Travel allowance and expense – provider site (from Part III, line 25)	
49.	Travel allowance and expense – HHA services (from Part IV, lines 34, 35 or 36)	
50.	Overtime allowance (from Part V, col. 4, line 46)	
51.	Equipment cost (See Instructions)	
52.	Supplies (See Instructions)	
53.	Total Allowance (Sum of lines 47–52)	
54.	Total cost of outside supplier services (from provider records)	
55.	Excess over limitation (line 54 minus line 53 – transfer amount to line 9, SCH. B-1, if negative, enter zero)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-2

RECLASSIFICATION TO EXPENSE

VENDOR NAME: _____ VENDOR NUMBER: _____

PERIOD ENDING: _____

(1) DESCRIPTION	(2) LINE #	(3) INCREASE	(4) <DECREASE>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34. TOTAL			

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE C

COST ALLOCATION STATISTICS

VENDOR NAME: _____ VENDOR 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 – HCB EXTENDED AREA				
30. CLIENT ASSESSMENT/REASSESSMENT				
31. CASE MANAGEMENT				
32. HOMEMAKER				
33. PERSONAL CARE				
34. RESPITE CARE				
35. HOME ADAPTATION				
NON-REIMBURSABLE				
36. WAIVER #1 (24HR)				
37. WAIVER #2 (16HR)				
38. _____				
39. _____				
40. TOTAL				
41. TOTAL TO ALLOCATE				
42. UNIT COST MULTIPLIER				

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE C–1

COST ALLOCATION

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

	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							
MEDICAL SUPPLIES							
SKILLED NURSING							
PHYSICAL THERAPY							
SPEECH THERAPY							
OCCUPATIONAL THERAPY							
MEDICAL SOCIAL SERVICES							
HOME HEALTH AIDES							
DIRECT SERVICES – HCB							
CLIENT ASSESSMENT/REASSESSMENT							
CASE MANAGEMENT							
HOMEMAKER							
PERSONAL CARE							
RESPITE CARE							
HOME ADAPTATION							
DIRECT SERVICES – HCB EXTENDED AREA							
CLIENT ASSESSMENT/REASSESSMENT							
CASE MANAGEMENT							
HOMEMAKER							
PERSONAL CARE							
RESPITE CARE							
HOME ADAPTATION							
NON–REIMBURSABLE							
WAIVER #1 (24HR)							
WAIVER #2 (16HR)							
_____							
_____							
TOTALS							

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

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

PART I:

PATIENT SERVICES	VISITS BEFORE 07-01-- AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/ VISITS	AVERAGE COST PER UNIT/VISITS	XVIII COST LIMITS	XIX COSTS LIMITS	XIX PROGRAM UNIT/VISITS	COST OF SERVICES AVERAGE	XVIII	XIX
1	2	3	4	5	6	7	8	9	10	11
1. SKILLED NURSING						XXXXXXX				
2. PHYSICAL THERAPY						XXXXXXX				
3. SPEECH THERAPY						XXXXXXX				
4. OCCUPATIONAL THERAPY						XXXXXXX				
5. MEDICAL SOCIAL SERVICES						XXXXXXX				
6. HOME HEALTH AID SERVICES						XXXXXXX				
7. TOTAL (SUM OF LINES 1-6)			XXXXXXXX	XXXXX	XXXXXXXXXXXXX	XXXXXXX				
8. TOTAL COST (LESSER OF COL. 9, 10, 11)										

PART II:

PATIENT SERVICES	VISITS AFTER 07-01-- AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/ VISITS	AVERAGE COST PER UNIT/VISITS	XVIII COST LIMITS	XIX COSTS LIMITS	XIX PROGRAM UNIT/VISITS	COST OF SERVICES AVERAGE	XVIII	XIX
1	2	3	4	5	6	7	8	9	10	11
1. SKILLED NURSING						XXXXXXX				
2. PHYSICAL THERAPY						XXXXXXX				
3. SPEECH THERAPY						XXXXXXX				
4. OCCUPATIONAL THERAPY						XXXXXXX				
5. MEDICAL SOCIAL SERVICES						XXXXXXX				
6. HOME HEALTH AID SERVICES						XXXXXXX				
7. TOTAL (SUM OF LINES 1-6)			XXXXXXXX	XXXXX	XXXXXXXXXXXXX	XXXXXXX				
8. TOTAL COST (LESSER OF COL. 9, 10, 11)							XXXXXXXXX			
9. TOTAL XIX VISITS (LINE 7, COL 8, PART I + LINE 7, COL 8, PART II)										

PART III:

MEDICAL SUPPLIES COMPUTATION

	TOTAL COST	TOTAL CHARGE	RATIO	XIX CHARGE	XIX COST
	1	2	3	4	5
1. MEDICAL SUPPLIES					
2. TOTAL COST OF SERVICES (LINE 8, COL 11, PART I + LINE 8, COL 11, PART II + LINE 1, COL. 5, PART III)					

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE D-1

CALCULATION OF REIMBURSEMENT SETTLEMENT

VENDOR NAME: _____ VENDOR # _____

PERIOD ENDING: _____

PART I – COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

1. COST OF SERVICES (FROM SCHEDULE D, PART III, LINE 2) _____
2. TOTAL CHARGES FOR TITLE XIX SERVICES (FROM PCL'S) _____
3. EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 2) _____

PART II COMPUTATION OF REIMBURSEMENT SETTLEMENT

4. TOTAL REASONABLE COST (FROM LINE 1) _____
5. EXCESS REASONABLE COST (FROM LINE 3) _____
6. SUBTOTAL (LINE 4 MINUS LINE 5) _____
7. AMOUNTS REC'D. FROM TPL / OTHER SOURCES (PCL'S) _____
8. AMOUNTS REC'D. FROM THE MEDICAID PROGRAM (PCL'S) _____
9. AMOUNT RECEIVED AS INCENTIVE PAYMENTS (PCL'S) _____
10. TOTAL INTERIM PAYMENTS (LINE 7 plus 8 minus 9) _____
11. BALANCE DUE PROVIDER / MEDICAID PROGRAM (LN. 6 minus 10) (INDICATE OVERPAYMENTS IN PARENTHESES) _____

ANNUAL COST REPORT
HOME AND COMMUNITY BASED
SCHEDULE E
APPORTIONMENT OF PATIENT SERVICE COSTS

VENDOR NAME:_____ VENDOR NUMBER:_____ PERIOD ENDING:_____

PART I — VISITS BEFORE 07-01-____

PATIENT SERVICE	AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISIT	XIX COST LIMITS	XIX UNIT/VISITS	COST OF SERVICES AVERAGE	COST OF SERVICES XIX
1	2	3	4	5	6	7	8
1. CLIENT ASSESSMENT/REASSESSMENT							
2. CASE MANAGEMENT							
3. HOMEMAKER							
4. PERSONAL CARE							
5. RESPITE CARE							
6. ADAPTATION PROGRAM							
7. TOTAL (SUM OF LINE 1-6)			XXXXXXXXXX	XXXXXXX			

PART II — VISITS AFTER 07-01-____

PATIENT SERVICE	AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISIT	XIX COST LIMITS	XIX UNIT/VISITS	COST OF SERVICES AVERAGE	COST OF SERVICES XIX
1	2	3	4	5	6	7	8
8. CLIENT ASSESSMENT/REASSESSMENT							
9. CASE MANAGEMENT							
10. HOMEMAKER							
11. PERSONAL CARE							
12. RESPITE CARE							
13. ADAPTATION PROGRAM							
14. TOTAL (SUM OF LINE 8-13)			XXXXXXXXXX	XXXXXXX			

PART III — CALCULATION OF REIMBURSEMENT SETTLEMENT

15. ALLOWABLE COST OF PATIENT SERVICES (LESSER OF LINE 7, COL. 7 OR LINE 7, COL. 8.)	
16. ALLOWABLE COST OF PATIENT SERVICES (LESSER OF LINE 14, COL. 7 OR LINE 14 COL 8.)	
17. TOTAL ALLOWABLE COST OF PATIENT SERVICES, (LINE 15 + LINE 16, LESS AMOUNTS FROM SCHEDULE E-1, AND E-2)	
18. TOTAL CHARGES FOR WAIVER PROGRAM SERVICES FROM PCL'S.	
19. REIMBURSABLE COST (LESSER OF LINE 17 OR LINE 18).	
20a. AMOUNT RECEIVED FROM PROGRAM FOR WAIVER PROGRAM SERVICES.	
20b. CONTINUING INCOME OR TPL.	
21. TOTAL RECEIVED (LINE 20a + 20b)	
22. BALANCE DUE (PROGRAM)/VENDOR (LINE 19 minus 21)	

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER
SCHEDULE E-1
RESPITE CARE COST LIMITATION

VENDOR NAME: ______________________________

VENDOR NO.: ____________ PERIOD ENDING: ____________

KMAP RECIPIENT 1	(A) RESPITE UNITS 2	AVG. COST 3	TOTAL COST 4	COST IN EXCESS OF LIMITATION (B) 5
TOTAL NON-ALLOWABLE COST (TO SCHEDULE E, LINE 17)				

(A) UNITS FOR FISCAL YEAR (COLUMN 2)

(B) COST IN EXCESS OF $2,000.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER
SCHEDULE E-2

STATEMENT TO HOME ADAPTATION EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

1. TOTAL ADAPTATION EXPENSE (FROM SCHEDULE E, LINE 6, COL 2) _____
2. DIRECT ADAPTATION EXPENSE (FROM SCHEDULE B, LINE 29, COL.6) _____
3. OVERHEAD FACTOR (DIVIDE LINE 1 by LINE 2) _____

KMAP RECIPIENT 1	DIRECT COST 2	ADJUSTED COST (A) 3	COST IN EXCESS OF LIMITATION (B) 4
—			
4. TOTAL NON-ALLOWABLE KMAP COST (TRANSFER TO SCH. E, LINE 17)			

(A) DIRECT COST X OVERHEAD FACTOR (LINE 3)

(B) COST IN EXCESS OF $500.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME AND COMMUNITY BASED (EXTENDED AREA)
SCHEDULE F

APPORTIONMENT OF PATIENT SERVICE COSTS

VENDOR NAME:_____ VENDOR NUMBER:_____ PERIOD ENDING:_____

PATIENT SERVICE	AMOUNTS (Sch C–1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISITS	XIX UNIT/VISITS	XIX COST
1	2	3	4	5	6
1. CLIENT ASSESSMENT/REASSESSMENT					
2. CASE MANAGEMENT					
3. HOMEMAKER					
4. PERSONAL CARE					
5. RESPITE CARE					
6. HOME ADAPTATION PROGRAM					
7. TOTAL (SUM OF LINE 1–6)			XXXXXXXXXXX		
8. ALLOWABLE COST OF PATIENT SERVICES (LINE 7, COL. 6)					
9. TOTAL OF ALLOWABLE COST OF PATIENT SERVICES, (LINE 8, LESS AMOUNTS FROM SCHEDULE F–1, AND F–2)_____					
10. TOTAL CHARGES FOR WAIVER PROGRAM SERVICES FROM PCL'S.					
11. REIMBURSABLE COST (LESSER OF LINE 9 OR LINE 10).					
12a. AMOUNT RECEIVED FROM PROGRAM FOR WAIVER PROGRAM SERVICES.					
12b. CONTINUING INCOME OR TPL.					
13. TOTAL RECEIVED (LINE 12a + 12b)					
14. BALANCE DUE (PROGRAM)/VENDOR (LINE 11 minus LINE 13)					

Transmittal #9
5/1/91

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER (EXTENDED AREA)
SCHEDULE F-1
RESPITE CARE COST LIMITATION

VENDOR NAME: ______________________________

VENDOR NO: ____________ PERIOD ENDING: ____________

KMAP RECIPIENT 1	(A) RESPITE UNITS 2	AVG. COST 3	TOTAL COST 4	COST IN EXCESS OF LIMITATION (B) 5
TOTAL NON-ALLOWABLE COST (TO SCHEDULE F, LINE 9)				

(A) UNITS FOR FISCAL YEAR (COLUMN 2)

(B) COST IN EXCESS OF $2,000.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER (EXTENDED AREA)
SCHEDULE F-2

STATEMENT TO HOME ADAPTATION EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

1. TOTAL ADAPTATION EXPENSE (FROM SCHEDULE E, LINE 6, COL 2) _____
2. DIRECT ADAPTATION EXPENSE (FROM SCHEDULE B, LINE 35, COL.6) _____
3. OVERHEAD FACTOR (DIVIDE LINE 1 by LINE 2) _____

KMAP RECIPIENT 1	DIRECT COST 2	ADJUSTED COST (A) 3	COST IN EXCESS OF LIMITATION (B) 4
4. TOTAL NON-ALLOWABLE KMAP COST (TRANSFER TO SCH. F, LINE 9)			

(A) DIRECT COST X OVERHEAD FACTOR (LINE 3)

(B) COST IN EXCESS OF $500.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE G
HOME HEALTH AGENCY DATA

VENDOR NAME: _____
VENDOR NUMBER: _____
PERIOD ENDING: _____

All vendors are to complete A, B, C and D

A. STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

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

_____ YES _____ NO

2. Enter related party transactions below, if additional space is required attach additional sheet(s).

SCHEDULE	LINE NO.	ITEM	AMOUNT

3. Name and percent of direct or indirect ownership of the related organization.

NAME OF OWNER	NAME OF RELATED ORGANIZATION	PERCENT

B. STATEMENT OF COMPENSATION OF OWNERS

			PARTNERS	CORPORATION OFFICERS	
NAME	TITLE AND FUNCTION	PERCENT OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT OF OPERATING PROFIT OR LOSS	PERCENT OF VENDOR'S STOCK OWNED	TOTAL COMPEN-SATION

C. STATEMENT OF COMPENSATION PAID TO ADMINISTRATORS AND / OR ASSISTANT ADMINISTRATORS (OTHER THAN OWNERS)

NAME	TITLE AND FUNCTION	PERCENT OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT OF PERIOD EMPLOYED	TOTAL COMPENSATION FOR THE PERIOD

D. CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

INTENTIONAL MISREPRESENTATIONS OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND / OR IMPRISONMENT UNDER FEDERAL LAW.

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

Signature of Officer or Director Title Date