(6/2003)

Kentucky Medicaid Medical Supply Cost Settlement Worksheet

Annual Cost Report

Provider Name: _____ Provider Number: _____

Fiscal Year Ending (FYE): _____

		Column 1	Column 2
1.	Title XIX Medical Supply Charges for the reporting period. (From Paid Claims Listings Summary)		
2.	Medical Supplies Cost to Charge Ratio. (From CMS-2552, Worksheet H-6 or CMS-1728 Worksheet C)		
3.	Title XIX Medical Supply Cost. (Multiply Line 1 by Line 2)		
4.	Lower of Cost or Charges: (Enter the Lessor of Line 1 or Line 3.)		
5.	Title XIX Medical Supply Payments (PCL's)		
6.	Amounts Rec'd From TPL/Other Sources (PCL's)		
7.	Total Interim Payments (Line 5 plus 6)		
8.	Total Balance Due Provider/Medicaid Program. (Subtact Line 7 from Line 4), (Indicate Overpayments In Parentheses)		

If Balance is Due Medicaid Program (Overpayments), cost report shall include check made payable to:

KENTUCKY STATE TREASURER

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 filed 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) _____

Officer or Administrator Signature and Title

Date: _____