

DRAFT

FINANCIAL AND STATISTICAL COST REPORT FOR PROVIDERS OF MENTAL RETARDATION SERVICES

CERTIFICATION PAGE

1	Provider Name:	ABC Company	
2	Address:		
3	City:	State:	ZIP:
4	Period of Report:	From:	To:
5	Administrator Name:		
6	Name of Person to Contact if Questions About Report:		

1a	MPI No.:	123456789
2a	IRS Tax ID No.:	
3a	Date of Fiscal Year End:	
4a	Telephone No. (Primary):	
5a	Telephone No. (Secondary):	
6a	County:	

7	Report Type:	Actual (Continuing Provider)	New Service (Continuing Provider)	New Provider
8	Type of Control:	Government	Non-Profit Organization	For Profit
9	Accounting Basis:	Accrual	Modified Cash	Cash
10	Years in Business:			
11	Does Provider have an independent audit?	Yes, for year ending:		No
12	Has a copy of the latest independent audit been submitted?	Yes		No

13 Form of Certification by Officer or Administrator of Provider:

I CERTIFY that I have examined the accompanying schedules of revenues and expenses and the calculations of cost of service prepared for this Provider and that to the best of my knowledge and belief they are true and correct. I also certify these schedules were prepared from the books and records of the Provider in accordance with instructions contained in this report, and allowable cost of care excludes expenses that were not necessary or allowable to provide this care. If a new Provider, I have completed only the Certification Schedules.

SIGNED

(Officer or Administrator of Facility)

(Title)

(Date)

14 Statement of Preparer (If Other Than Provider)

I have prepared this report and to the best of my knowledge and belief, it represents true and accurate data of the Provider stated above.

(Signed)

(Date)

CERTIFICATION PAGE – PROVIDER SITE SHEET

Number of Sites: 10

	Site #1 Site Included in Cost Report?	
1	Yes	LOCATION CODE
2	No	COUNTY
3		SITE ADDRESS (If different Than Provider Address)
4		SITE NAME
5		CITY, STATE, ZIP CODE
6		
	Site #2 Site Included in Cost Report?	
7	Yes	LOCATION CODE
8	No	COUNTY
9		SITE ADDRESS (If different Than Provider Address)
10		SITE NAME
11		CITY, STATE, ZIP CODE
12		
	Site #3 Site Included in Cost Report?	
13	Yes	LOCATION CODE
14	No	COUNTY
15		SITE ADDRESS (If different Than Provider Address)
16		SITE NAME
17		CITY, STATE, ZIP CODE
18		
	Site #4 Site Included in Cost Report?	
19	Yes	LOCATION CODE
20	No	COUNTY
21		SITE ADDRESS (If different Than Provider Address)
22		SITE NAME
23		CITY, STATE, ZIP CODE
24		
	Site #5 Site Included in Cost Report?	
25	Yes	LOCATION CODE
26	No	COUNTY
27		SITE ADDRESS (If different Than Provider Address)
28		SITE NAME
29		CITY, STATE, ZIP CODE
30		
	Site #6 Site Included in Cost Report?	
31	Yes	LOCATION CODE
32	No	COUNTY
33		SITE ADDRESS (If different Than Provider Address)
34		SITE NAME
35		CITY, STATE, ZIP CODE
36		
	Site #7 Site Included in Cost Report?	
37	Yes	LOCATION CODE
38	No	COUNTY
39		SITE ADDRESS (If different Than Provider Address)
40		SITE NAME
41		CITY, STATE, ZIP CODE
42		

CERTIFICATION PAGE – PROVIDER SITE SHEET

	Site #8 Site Included in Cost Report?	
43	Yes	LOCATION CODE
44	No	COUNTY
45		SITE ADDRESS (If different Than Provider Address)
46		SITE NAME
47		CITY, STATE, ZIP CODE
48		
	Site #9 Site Included in Cost Report?	
49	Yes	LOCATION CODE
50	No	COUNTY
51		SITE ADDRESS (If different Than Provider Address)
52		SITE NAME
53		CITY, STATE, ZIP CODE
54		
	Site #10 Site Included in Cost Report?	
55	Yes	LOCATION CODE
56	No	COUNTY
57		SITE ADDRESS (If different Than Provider Address)
58		SITE NAME
59		CITY, STATE, ZIP CODE
60		

CERTIFICATION PAGE – SERVICE SELECTION

		Codes	Bill Unit	Waiver	Base
Home and Community Based Services					
1	- Base Staff Support no less than 1:6	W7057	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
2	- Staff Support Level 1 of <1:6 to 1:3.5	W7058	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
3	- Staff Support Level 2 of <1:3.5 to >1:1	W7059	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4	- Staff Support Level 3 of 1:1	W7060	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
5	- Level 3 Enhanced	W7061	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Licensed Day Services					
6	- Base Staff Support no less than 1:6	W7072	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
7	- Staff Support Level 1 of <1:6 to 1:3.5	W7073	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
8	- Staff Support Level 2 of <1:3.5 to >1:1	W7074	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
9	- Staff Support Level 3 of 1:1	W7075	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
10	- Level 3 Enhanced	W7076	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
11	- Licensed Older Adult Day Services	W7094	15 min	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Prevocational Services					
12	- Base Staff Support no less than 1:15	W7087	15 min	<input type="checkbox"/>	<input type="checkbox"/>
13	- Staff Support Level 1 of <1:15 to 1:7.5	W7088	15 min	<input type="checkbox"/>	<input type="checkbox"/>
14	- Staff Support Level 2 of <1:7.5 to >1:1	W7089	15 min	<input type="checkbox"/>	<input type="checkbox"/>
15	- Staff Support Level 3 of 1:1	W7090	15 min	<input type="checkbox"/>	<input type="checkbox"/>
16	- Level 3 Enhanced	W7091	15 min	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION PAGE – SERVICE SELECTION

		Codes	Bill Unit	Waiver	Base
Residential Habilitation - Licensed					
17	- Child Residential Services - Eligible	W7097	1/2 month	<input type="checkbox"/>	<input type="checkbox"/>
18	- Child Residential Services - Ineligible	W7098	1/2 month		<input type="checkbox"/>
19	- Community Residential Rehab for the Mentally Ill - Eligible	W7202	1/2 month	<input type="checkbox"/>	<input type="checkbox"/>
20	- Community Residential Rehab for the Mentally Ill - Ineligible	W7203	1/2 month		<input type="checkbox"/>
21	- Community Home for Mental Retardation - Eligible	W7220	1/2 month	<input type="checkbox"/>	<input type="checkbox"/>
22	- Community Home for Mental Retardation - Ineligible	W7221	1/2 month		<input type="checkbox"/>

Residential Habilitation - Unlicensed					
23	- Unlicensed Community Residential - Eligible	W7226	1/2 month	<input type="checkbox"/>	<input type="checkbox"/>
24	- Unlicensed Community Residential - Ineligible	W7227	1/2 month		<input type="checkbox"/>

25	Supported Employment	W7235	15 min	<input type="checkbox"/>	<input type="checkbox"/>
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Transitional Work Service					
26	- Base Staff Support no less than 1:6	W7237	15 min	<input type="checkbox"/>	<input type="checkbox"/>
27	- Staff Support Level 1 of <1:6 to 1:3.5	W7239	15 min	<input type="checkbox"/>	<input type="checkbox"/>
28	- Staff Support Level 2 of <1:3.5 to >1:1	W7241	15 min	<input type="checkbox"/>	<input type="checkbox"/>
29	- Staff Support Level 3 of 1:1	W7243	15 min	<input type="checkbox"/>	<input type="checkbox"/>
30	- Level 3 Enhanced	W7245	15 min	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION PAGE – SERVICE SELECTION

		Codes	Bill Unit	Waiver	Base
Respite Services					
31	- In-Home Respite 24 hours Base Staff Support 1:4	W7247	Day	<input type="checkbox"/>	<input type="checkbox"/>
32	- In-Home Respite 24 hours Level 1 Staff Support <1:4 to >1:1	W7248	Day	<input type="checkbox"/>	<input type="checkbox"/>
33	- In-Home Respite 24 hours Level 2 Staff Support 1:1	W7249	Day	<input type="checkbox"/>	<input type="checkbox"/>
34	- In-Home Respite 24 hours Level 2 Enhanced Staff Support 2:1	W7250	Day	<input type="checkbox"/>	<input type="checkbox"/>
35	- In-Home Respite 15 min Base Staff Support 1:4	W7255	15 min	<input type="checkbox"/>	<input type="checkbox"/>
36	- In-Home Respite 15 min Level 1 Staff Support <1:4 to >1:1	W7256	15 min	<input type="checkbox"/>	<input type="checkbox"/>
37	- In-Home Respite 15 min Level 2 Staff Support 1:1	W7257	15 min	<input type="checkbox"/>	<input type="checkbox"/>
38	- In-Home Respite 15 min Level 2 Enhanced Staff Support 2:1	W7258	15 min	<input type="checkbox"/>	<input type="checkbox"/>
39	- Out-of-Home Respite 24 hours Base Staff Support 1:4	W7259	Day	<input type="checkbox"/>	<input type="checkbox"/>
40	- Out-of-Home Respite 24 hours Level 1 Staff Support <1:4 to >1:1	W7260	Day	<input type="checkbox"/>	<input type="checkbox"/>
41	- Out-of-Home Respite 24 hours Level 2 Staff Support 1:1	W7261	Day	<input type="checkbox"/>	<input type="checkbox"/>
42	- Out-of-Home Respite 24 hours Level 2 Enhanced Staff Support 2:1	W7262	Day	<input type="checkbox"/>	<input type="checkbox"/>
43	- Out-of-Home Respite 15 min Base Staff Support 1:4	W7267	15 min	<input type="checkbox"/>	<input type="checkbox"/>
44	- Out-of-Home Respite 15 min Level 1 Staff Support <1:4 to >1:1	W7268	15 min	<input type="checkbox"/>	<input type="checkbox"/>
45	- Out-of-Home Respite 15 min Level 2 Staff Support 1:1	W7269	15 min	<input type="checkbox"/>	<input type="checkbox"/>
46	- Out-of-Home Respite 15 min Level 2 Enhanced Staff Support 2:1	W7270	15 min	<input type="checkbox"/>	<input type="checkbox"/>
47	- Overnight Camp	W7285	Day	<input type="checkbox"/>	<input type="checkbox"/>
48	- Day Camp	W7286	Day	<input type="checkbox"/>	<input type="checkbox"/>

CERTIFICATION PAGE – SERVICE SELECTION

		Codes	Bill Unit	Waiver	Base
Transportation Services					
49	- Mile	W7271	Mile	<input type="checkbox"/>	<input type="checkbox"/>
50	- Public Transportation	W7272	Day	<input type="checkbox"/>	<input type="checkbox"/>
51	- Per Diem	W7273	Day	<input type="checkbox"/>	<input type="checkbox"/>
52	- Trip - Zone 1 Shortest Distance From Site	W7274	Trip (One Way)	<input type="checkbox"/>	<input type="checkbox"/>
53	- Trip - Zone 2 Based on Middle Distance From Site	W7275	Trip (One Way)	<input type="checkbox"/>	<input type="checkbox"/>
54	- Trip - Zone 3 Based on Longest Distance From Site	W7276	Trip (One Way)	<input type="checkbox"/>	<input type="checkbox"/>

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PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A - EXPENSE REPORT (Waiver)

A B C D E F G

	Total Provider Expenses	Excluded Sites Expenses	Other LOB Expenses	Base Expenses	Residential Occupancy Expenses	Excluded Non-Allowable Waiver Expenses	Allowable Waiver Expenses
DIRECT CARE EXPENSES							
1 Direct Care Staff Salary/Wages (Schedule D)							
2 Direct Care Staff ERE (Schedule D)							
3 Direct Care Contracted Staff (Schedule D)							
4 Transportation (Schedule E)							
5 Other - Direct Non-Salary Expenses							
6 TOTAL DIRECT CARE EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
INDIRECT PROGRAM EXPENSES							
7 Indirect Staff Salary/Wages/ERE (Schedule D-1)							
8 Indirect Contracted Staff (Schedule D-1)							
9 Program Supplies							
10 Staff Development and Training							
11 Transportation (Schedule E)							
12 Other - Indirect Expenses							
13 TOTAL INDIRECT PROGRAM EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
ADMINISTRATIVE EXPENSES							
14 Administrative Staff Salary/Wages/ERE (Schedule D-2)							
15 General and Administrative Expenses (Schedule F)							
16 Occupancy Expenses (Schedule F)							
17 Depreciation - Equipment/Buildings (Schedule E)							
18 TOTAL ADMINISTRATIVE EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19 TOTAL EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20 CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)							
21 EXPENSES, NET OF CONTRIBUTIONS/REVENUE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CAPACITY / UNITS OF SERVICE							
22 No. of Units of Service (Licensed or Staffed) Available							
23 Type of Unit (15 Min., Daily, etc.)							
24 Total Number of Units of Service Provided							
25 Cost Per Historical Unit of Service (Line 21 / Line 24)							

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PROVIDER NAME: ABC Company
MPT NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A - EXPENSE REPORT (Waiver)

	H Home and Community Based Services W7057	I Home and Community Based Services W7058	J Home and Community Based Services W7059	K Home and Community Based Services W7060	L Home and Community Based Services W7061	M Licensed Day Services W7072	N Licensed Day Services W7073
	- Base Staff Support no less than 1:6	- Staff Support Level 1 of <1:6 to 1:3.5	- Staff Support Level 2 of <1:3.5 to >1:1	- Staff Support Level 3 of 1:1	- Level 3 Enhanced	- Base Staff Support no less than 1:6	- Staff Support Level 1 of <1:6 to 1:3.5
	15 min	15 min	15 min	15 min	15 min	15 min	15 min
DIRECT CARE EXPENSES							
1	Direct Care Staff Salary/Wages (Schedule D)						
2	Direct Care Staff ERE (Schedule D)						
3	Direct Care Contracted Staff (Schedule D)						
4	Transportation (Schedule E)						
5	Other - Direct Non-Salary Expenses						
6	TOTAL DIRECT CARE EXPENSES						
INDIRECT PROGRAM EXPENSES							
7	Indirect Staff Salary/Wages/ERE (Schedule D-1)						
8	Indirect Contracted Staff (Schedule D-1)						
9	Program Supplies						
10	Staff Development and Training						
11	Transportation (Schedule E)						
12	Other - Indirect Expenses						
13	TOTAL INDIRECT PROGRAM EXPENSES						
ADMINISTRATIVE EXPENSES							
14	Administrative Staff Salary/Wages/ERE (Schedule D-2)						
15	General and Administrative Expenses (Schedule F)						
16	Occupancy Expenses (Schedule F)						
17	Depreciation - Equipment/Buildings (Schedule E)						
18	TOTAL ADMINISTRATIVE EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19	TOTAL EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20	CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)						
21	EXPENSES, NET OF CONTRIBUTIONS/REVENUE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CAPACITY / UNITS OF SERVICE							
22	No. of Units of Service (Licensed or Staffed) Available	15 min	15 min	15 min	15 min	15 min	15 min
23	Type of Unit (15 Min., Daily, etc.)						
24	Total Number of Units of Service Provided						
25	Cost Per Historical Unit of Service (Line 21 / Line 24)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

DRAFT

PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A - EXPENSE REPORT (Waiver)

	O	P	R	S	T	U	V
	Licensed Day Services	Licensed Day Services	Licensed Day Services	Licensed Day Services			
	W7074	W7075	W7076	W7094			
	- Staff Support Level 2 of <1:3.5 to >1:1	- Staff Support Level 3 of 1:1	- Level 3 Enhanced	- Licensed Older Adult Day Services			
	15 min	15 min	15 min	15 min			
DIRECT CARE EXPENSES							
1	Direct Care Staff Salary/Wages (Schedule D)						
2	Direct Care Staff FEE (Schedule D)						
3	Direct Care Contracted Staff (Schedule D)						
4	Transportation (Schedule E)						
5	Other - Direct Non-Salary Expenses						
6	TOTAL DIRECT CARE EXPENSES						
INDIRECT PROGRAM EXPENSES							
7	Indirect Staff Salary/Wages/ERE (Schedule D-1)						
8	Indirect Contracted Staff (Schedule D-1)						
9	Program Supplies						
10	Staff Development and Training						
11	Transportation (Schedule E)						
12	Other - Indirect Expenses						
13	TOTAL INDIRECT PROGRAM EXPENSES						
ADMINISTRATIVE EXPENSES							
14	Administrative Staff Salary/Wages/ERE (Schedule D-2)						
15	General and Administrative Expenses (Schedule F)						
16	Occupancy Expenses (Schedule F)						
17	Depreciation - Equipment/Buildings (Schedule E)						
18	TOTAL ADMINISTRATIVE EXPENSES						
19	TOTAL EXPENSES						
20	CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)						
21	EXPENSES, NET OF CONTRIBUTIONS/REVENUE						
CAPACITY / UNITS OF SERVICE							
22	No. of Units of Service (Licensed or Staffed) Available						
23	Type of Unit (15 Min., Daily, etc.)	15 min	15 min	15 min	15 min		
24	Total Number of Units of Service Provided						
25	Cost Per Historical Unit of Service (Line 21 / Line 24)						

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PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A-1 - EXPENSE REPORT (Base)

	A	B	C	D	E	F	G
	Base Expenses	Base Non Waiver, Excluding Room & Board Expenses	Excluded Non-Allowable Expenses	Allowable Base Expenses	Home and Community Based Services W7057	Home and Community Based Services W7058	Home and Community Based Services W7059
					Support no less than 1:6	Support Level 1 of <1:6 to 1:3.5	Support Level 2 of <1:3.5 to >1:1
					15 min	15 min	15 min
DIRECT CARE EXPENSES							
1 Direct Care Staff Salary/Wages (Schedule D)							
2 Direct Care Staff ERE (Schedule D)							
3 Direct Care Contracted Staff (Schedule D)							
4 Transportation (Schedule E)							
5 Other - Direct Non-Salary Expenses							
6 TOTAL DIRECT CARE EXPENSES	\$ -	\$ -	\$ -	\$ -			
INDIRECT PROGRAM EXPENSES							
7 Indirect Staff Salary/Wages/ERE (Schedule D-1)							
8 Indirect Contracted Staff (Schedule D-1)							
9 Program Supplies							
10 Staff Development and Training							
11 Transportation (Schedule E)							
12 Other - Indirect Expenses							
13 TOTAL INDIRECT PROGRAM EXPENSES	\$ -	\$ -	\$ -	\$ -			
ADMINISTRATIVE EXPENSES							
14 Administrative Staff Salary/Wages/ERE (Schedule D-2)							
15 General and Administrative Expenses (Schedule F)							
16 Occupancy Expenses (Schedule F)							
17 Depreciation - Equipment/Buildings (Schedule E)							
18 TOTAL ADMINISTRATIVE EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
19 TOTAL EXPENSES	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
20 CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)							
21 EXPENSES, NET OF CONTRIBUTIONS/REVENUE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
CAPACITY / UNITS OF SERVICE							
22 No. of Units of Service (Licensed or Staffed) Available					15 min	15 min	15 min
23 Type of Unit (15 Min., Daily, etc.)							
24 Total Number of Units of Service Provided							
25 Cost Per Historical Unit of Service (Line 21 / Line 24)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

DRAFT

PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A-1 - EXPENSE REPORT (Base)

	H	I	J	K	L	M	N
	Home and Community Based Services W7060	Home and Community Based Services W7061	Licensed Day Services W7072	Licensed Day Services W7073	Licensed Day Services W7074	Licensed Day Services W7075	Licensed Day Services W7076
	- Staff Support Level 3 of 1:1 15 min	- Level 3 Enhanced 15 min	- Base Staff Support no less than 1:6 15 min	- Staff Support Level 1 of <1:3.5 to >1:1 15 min	- Staff Support Level 2 of <1:3.5 to >1:1 15 min	- Staff Support Level 3 of 1:1 15 min	- Level 3 Enhanced 15 min
DIRECT CARE EXPENSES							
1	Direct Care Staff Salary/Wages (Schedule D)						
2	Direct Care Staff FEE (Schedule D)						
3	Direct Care Contracted Staff (Schedule D)						
4	Transportation (Schedule E)						
5	Other - Direct Non-Salary Expenses						
6	TOTAL DIRECT CARE EXPENSES						
INDIRECT PROGRAM EXPENSES							
7	Indirect Staff Salary/Wages/FEE (Schedule D-1)						
8	Indirect Contracted Staff (Schedule D-1)						
9	Program Supplies						
10	Staff Development and Training						
11	Transportation (Schedule E)						
12	Other - Indirect Expenses						
13	TOTAL INDIRECT PROGRAM EXPENSES						
ADMINISTRATIVE EXPENSES							
14	Administrative Staff Salary/Wages/FEE (Schedule D-2)						
15	General and Administrative Expenses (Schedule F)						
16	Occupancy Expenses (Schedule F)						
17	Depreciation - Equipment/Buildings (Schedule E)						
18	TOTAL ADMINISTRATIVE EXPENSES						
19	TOTAL EXPENSES						
20	CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)						
21	EXPENSES, NET OF CONTRIBUTIONS/REVENUE						
CAPACITY / UNITS OF SERVICE							
22	No. of Units of Service (Licensed or Staffed) Available	15 min	15 min	15 min	15 min	15 min	15 min
23	Type of Unit (15 Min., Daily, etc.)						
24	Total Number of Units of Service Provided						
25	Cost Per Historical Unit of Service (Line 21 / Line 24)						

DRAFT

PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE A-1 - EXPENSE REPORT (Base)

O P Q R S T U

Licensed Day Services
W7094
- Licensed Older Adult Day Services

	O	P	Q	R	S	T	U
DIRECT CARE EXPENSES							
1 Direct Care Staff Salary/Wages (Schedule D)							
2 Direct Care Staff ERE (Schedule D)							
3 Direct Care Contracted Staff (Schedule D)							
4 Transportation (Schedule E)							
5 Other - Direct Non-Salary Expenses							
6 TOTAL DIRECT CARE EXPENSES							
INDIRECT PROGRAM EXPENSES							
7 Indirect Staff Salary/Wages/ERE (Schedule D-1)							
8 Indirect Contracted Staff (Schedule D-1)							
9 Program Supplies							
10 Staff Development and Training							
11 Transportation (Schedule E)							
12 Other - Indirect Expenses							
13 TOTAL INDIRECT PROGRAM EXPENSES							
ADMINISTRATIVE EXPENSES							
14 Administrative Staff Salary/Wages/ERE (Schedule D-2)							
15 General and Administrative Expenses (Schedule F)							
16 Occupancy Expenses (Schedule F)							
17 Depreciation - Equipment/Buildings (Schedule E)							
18 TOTAL ADMINISTRATIVE EXPENSES							
19 TOTAL EXPENSES							
CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)							
20 CONTRIBUTIONS/REVENUE (EXPENSE OFFSET)							
21 EXPENSES, NET OF CONTRIBUTIONS/REVENUE							
CAPACITY / UNITS OF SERVICE							
22 No. of Units of Service (Licensed or Staffed) Available							
23 Type of Unit (15 Min., Daily, etc.)							
24 Total Number of Units of Service Provided							
25 Cost Per Historical Unit of Service (Line 21 / Line 24)							

SCHEDULE B – INCOME STATEMENT

		A	B
REVENUES :		Total Provider Revenue/Expenses	Allowable Waiver Revenue/Expenses
Fee for Service / Other Income :			
1	Commonwealth of Pennsylvania		
2	County		
3	Private Clients		
4	United Way (service fees only)		
5	Social Security, SSI, SSA		
6	Investment Income		
7	Other (please list separately if greater than 5% of total revenue)		
Contributions :			
United Way :			
8	Contributions not Restricted / Appropriated		
9	Restricted / Appropriated Contributions		
Other (please describe):			
10	Contributions not Restricted / Appropriated		
11			
12	Restricted / Appropriated Contributions		
13			
14			
15			
Government Grants :			
16			
17			
18			
19	TOTAL REVENUE	\$ -	\$ -

EXPENSES (from Schedule A):

20	Direct Care Expenses	\$ -	\$ -
21	Indirect Program Expenses	\$ -	\$ -
22	Administrative Expenses	\$ -	\$ -
23	TOTAL EXPENSES	\$ -	\$ -

24	NET INCOME (LOSS)	\$ -	\$ -
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1 - Should equal Schedule A, A-19
 2 - Should equal Schedule A, G-19

SCHEDULE C – COMPARATIVE BALANCE SHEET (Total Provider Only)

ASSETS, LIABILITIES AND EQUITY

		A		B	
		Balance At End Of			
ASSETS:		Current Period		Prior Period	
1	Cash				
2	Receivable from Individuals				
3	Receivable from Others				
Property and Equipment:					
4	Land				
5	Buildings and Equipment (Schedule E)	\$	1 -		
6	Less Allowance for Depreciation				
7	Net Property and Equipment	\$	-	\$	-
8	Investments and Other Assets				
9	TOTAL ASSETS	\$	-	\$	-

LIABILITIES AND EQUITY:					
10	Accounts Payable				
11	Accrued Taxes (Payroll and Property)				
12	Other Liabilities				
13					
14					
15	Notes and Mortgages				
16	TOTAL LIABILITIES	\$	-	\$	-
17	Equity or Fund Balance				
18	TOTAL LIABILITIES AND EQUITY	\$	-	\$	-

RECONCILIATION OF EQUITY OR FUND BALANCE					
19	TOTAL EQUITY OR FUND BALANCE BEGINNING OF PERIOD	\$	-		
<u>Add:</u>					
20	TOTAL REVENUE from Schedule B				
21					
22					
23					
<u>Deduct:</u>					
24	TOTAL EXPENSES from Schedule A				
25					
26					
27					
28	TOTAL EQUITY OR FUND BALANCE END OF PERIOD	\$	-	\$	-

I - Should equal Schedule E, B-74

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PROVIDER NAME:
MPI NO.:
PERIOD OF REPORT:

ABC Company
123456789
01/00/1900 to 01/00/1900

SCHEDULE D - DIRECT CARE STAFFING EXPENSES

DIRECT CARE STAFF		ERE									
		A	B	C	D	E	F	G	H	I	J
Position	Credentials, License, or Degree	Provider Salary / Wages	Waiver Salary / Wages	Health Benefits	Retirement Plan	Other Benefits	Payroll Taxes	Total Waiver ERE	Provider Total Hours	Waiver Total Hours	
1	Direct Care Staff, Full Time										
2	Direct Care Staff, Full Time										
3	Direct Care Staff, Full Time										
4	Direct Care Staff, Part Time										
5	Other (Specify)										
6	Other (Specify)										
7	Other (Specify)										
8	Total	1	2	\$ -	\$ -	\$ -	\$ -	3	-	-	

DIRECT CARE CONTRACTED STAFF		ERE									
		A	B	C	D	E	F	G	H	I	J
Position	Credentials, License, or Degree	Provider Fees	Waiver Fees	Health Benefits	Retirement Plan	Other Benefits	Payroll Taxes	Total Waiver ERE	Provider Total Hours	Waiver Total Hours	
9	Direct Care Contracted Staff, Full Time										
10	Direct Care Contracted Staff, Full Time										
11	Direct Care Contracted Staff, Full Time										
12	Direct Care Contracted Staff, Part Time										
13	Other (Specify)										
14	Other (Specify)										
15	Other (Specify)										
16	Total	4	5	\$ -	\$ -	\$ -	\$ -		-	-	

1 - Should equal Schedule A, A-1
2 - Should equal Schedule A, G-1
3 - Should equal Schedule A, G-2
4 - Should equal Schedule A, A-3
5 - Should equal Schedule A, G-3

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PROVIDER NAME: ABC Company
 MPI NO.: 123456789
 PERIOD OF REPORT: 01/00/1900 to 01/00/1900

SCHEDULE D-1 - INDIRECT STAFFING EXPENSES

INDIRECT STAFF	Position	A Credentials, License, or Degree	ERE					I Total Waiver Salary/ Wages/ERE	J Provider Total Hours	K Waiver Total Hours
			B Provider Salary / Wages	C Waiver Salary / Wages	D Health Benefits	E Retirement Plan	F Other Benefits			
1	Indirect Staff, Full Time	RN								
2	Indirect Staff, Full Time	MSN								
3	Indirect Staff, Full Time	Other								
4	Indirect Staff, Part Time									
5	Other (Specify)									
6	Other (Specify)									
7	Other (Specify)									
8	Total		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-	-

INDIRECT CONTRACTED STAFF	Position	A Credentials, License, or Degree	ERE					I Total Waiver Fees	J Provider Total Hours	K Waiver Total Hours
			B Provider Fees	C Waiver Fees	D Health Benefits	E Retirement Plan	F Other Benefits			
9	Indirect Contracted Staff, Full Time	RN								
10	Indirect Contracted Staff, Full Time	MSN								
11	Indirect Contracted Staff, Full Time	Other								
12	Indirect Contracted Staff, Part Time									
13	Other (Specify)									
14	Other (Specify)									
15	Other (Specify)									
16	Total		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-	-

1 - Should equal Schedule A, G-7
 2 - Should equal Schedule A, G-8

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PROVIDER NAME:
 MPI NO.:
 PERIOD OF REPORT:

ABC Company
 123456789
 01/00/1900 to 01/00/1900

SCHEDULE D-2 - ADMINISTRATIVE STAFFING EXPENSES

ADMINISTRATIVE STAFF	A	B	C	ERE				H	I	J	K
				D	E	F	G				
Position	Credentials, License, or Degree	Provider Salary / Wages	Waiver Salary / Wages	Health Benefits	Retirement Plan	Other Benefits	Payroll Taxes	Total Waiver ERE	Total Waiver Salary/ Wages/ERE	Provider Total Hours	Waiver Total Hours
1	CEO							\$ -	\$ -		
2	CFO							\$ -	\$ -		
3	Other (Specify)							\$ -	\$ -		
4	Other (Specify)							\$ -	\$ -		
5	Other (Specify)							\$ -	\$ -		
6	Other (Specify)							\$ -	\$ -		
7	Total	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	-	-

1 - Should equal Schedule A, G-14

SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

		A	B	C	D	E	F
		Year Acquired	Original Cost	Depreciation Recorded Prior Years	Deprec. Method	Annual Rate	Depreciation Expense
OCCUPANCY/BUILDINGS:							
Buildings							
1					SL		
2					SL		
3					SL		
4					SL		
5					SL		
6					SL		
7					SL		
Additions							
8					SL		
9					SL		
10					SL		
11					SL		
12					SL		
13					SL		
14					SL		
Leasehold Improvements							
15					SL		
16					SL		
17					SL		
18					SL		
19					SL		
Other							
20					SL		
21					SL		
22					SL		
23					SL		
24	TOTAL OCCUPANCY & BUILDINGS		\$ -	\$ -			\$ -

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SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

		A	B	C	D	E	F
		Year Acquired	Original Cost	Depreciation Recorded Prior Year	Deprec. Method	Annual Rate	Depreciation Expense
MOTOR VEHICLES:							
Direct							
25					SL		
26					SL		
27					SL		
28	SUBTOTAL		\$ -	\$ -			\$ -
Indirect							
29					SL		
30					SL		
31					SL		
32	SUBTOTAL		\$ -	\$ -			\$ -
Administrative							
33					SL		
34					SL		
35					SL		
36	SUBTOTAL		\$ -	\$ -			\$ -
37	TOTAL TRANSPORTATION		\$ -	\$ -			\$ -

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SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

		A	B	C	D	E	F
		Year Acquired	Original Cost	Depreciation Recorded Prior Year	Deprec. Method	Annual Rate	Depreciation Expense
FIXED ASSETS/EQUIPMENT:							
Building Equipment							
38					SL		
39					SL		
40					SL		
41					SL		
42					SL		
43					SL		
44					SL		
Departmental Equipment							
45					SL		
46					SL		
47					SL		
48					SL		
49					SL		
50					SL		
51					SL		
Other Equipment							
52					SL		
53					SL		
54					SL		
55					SL		
56					SL		
57					SL		
58					SL		
Office Furniture & Fixtures							
59					SL		
60					SL		
61					SL		
62					SL		
63					SL		
64					SL		
65					SL		
Other							
66					SL		
67					SL		
68					SL		
69					SL		
70					SL		
71					SL		
72					SL		
73	TOTAL FIXED ASSETS/EQUIPMENT		\$ -	\$ -			\$ -

74	TOTAL (Line 24 + Line 73)	(ALL DEPRECIATION AND AMORTIZATION)	\$ -	\$ -			\$ -
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1 - Should equal Schedule A, A-17

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PROVIDER NAME:
 MPI NO.:
 PERIOD OF REPORT:

ABC Company
 123456789
 01/00/1900 to 01/00/1900

SCHEDULE F - ADMINISTRATIVE AND OCCUPANCY EXPENSES

General and Administrative		A
		Total Expenses
1	Management Fees	
2	Professional Services	
3	Advertising / Marketing	
4	Telephone	
5	Insurance	
6	Interest - Short Term Borrowing	
7	Legal Fees	
8	Accounting and Auditing	
9	Office Supplies	
10	Information Systems	
11	Professional Dues	
12	Administrative Transportation	
13	Other (please list separately if greater than 5% of total revenue)	
14	TOTAL ADMINISTRATIVE EXPENSES	\$

Occupancy Expenses	
15	Rent of Space
16	Utilities & Maintenance
17	Interest Expense - Buildings
18	Insurance and Property Tax
19	Other Occupancy
20	TOTAL OCCUPANCY EXPENSES
	\$

1 - Should equal Schedule A, G-16

SCHEDULE H – DIRECT CARE EXPENSE ALLOCATION PROCEDURES

Any expense allocable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies, or to avoid other restrictions imposed by law or terms of an award or program.

Direct Care Expenses:

Note: In general there should be no necessary allocation to direct care expenses. However, this schedule has been included in the event that current accounting systems limit providers ability to capture direct care expense specific to each procedure code.

1. Please describe which direct expenses are allocated.

2. What is your method for allocating direct expenses? Note instructions for acceptable forms of allocation. Attach supporting documentation.

3. Do you have accounting workpapers available to support direct expense allocations?

YES NO

4. Is your method of allocating direct service expenses consistently followed from year to year?

5. Are expenses allocated to services in reasonable proportion to benefits received?

6. Are service income deductions allocated in a manner which is consistent with the expenses incurred in generating the income?

7. Additional comments regarding allocation of direct service expenses:

SCHEDULE H-2 – ADMINISTRATIVE EXPENSE ALLOCATION PROCEDURES

Any expense allocable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies, or to avoid other restrictions imposed by law or terms of an award or program.

Note: If the Administrative Expense allocation procedures are the same as the Indirect Program Expense allocation procedures, please indicate that in Line 1 and do not complete the remaining questions.

Administrative Expenses:

1. Please describe which administrative expenses are allocated.

2. What is your method for allocating administrative expenses? Note instructions for acceptable forms of allocation. Attach supporting documentation.

- | | YES | NO |
|---|-------|-------|
| 3. Do you have accounting workpapers available to support administrative expense allocations? | _____ | _____ |
| 4. Is your method of allocating administrative expenses consistently followed from year to year? | _____ | _____ |
| 5. Are expenses allocated to services in reasonable proportion to benefits received? | _____ | _____ |
| 6. Are service income deductions allocated in a manner which is consistent with the expenses incurred in generating the income? | _____ | _____ |

7. Additional comments regarding allocation of administrative expenses:

SCHEDULE H-1 – INDIRECT PROGRAM EXPENSE ALLOCATION PROCEDURES

Any expense allocable to a particular service under the above principles may not be shifted to other services to overcome funding deficiencies, or to avoid other restrictions imposed by law or terms of an award or program.

Indirect Program Expenses:

1. Please describe which indirect expenses are allocated.

2. What is your method for allocating indirect expenses? Note instructions for acceptable forms of allocation. Attach supporting documentation.

- | | YES | NO |
|---|-------|-------|
| 3. Do you have accounting workpapers available to support indirect expense allocations? | _____ | _____ |
| 4. Is your method of allocating indirect expenses consistently followed from year to year? | _____ | _____ |
| 5. Are expenses allocated to services in reasonable proportion to benefits received? | _____ | _____ |
| 6. Are service income deductions allocated in a manner which is consistent with the expenses incurred in generating the income? | _____ | _____ |
| 7. Additional comments regarding allocation of indirect expenses: | | |
