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	☑	☑
2	- Staff Support Level 1 of <1:6 to 1:3.5	W7058	15 min	☑	☑
3	- Staff Support Level 2 of <1:3.5 to >1:1	W7059	15 min	☑	☑
4	- Staff Support Level 3 of 1:1	W7060	15 min	☑	☑
5	- Level 3 Enhanced	W7061	15 min	☑	☑
	Licensed Day Services				
6	- Base Staff Support no less than 1:6	W7072	15 min	☑	☑
7	- Staff Support Level 1 of <1:6 to 1:3.5	W7073	15 min	☑	☑
8	- Staff Support Level 2 of <1:3.5 to >1:1	W7074	15 min	☑	☑
9	- Staff Support Level 3 of 1:1	W7075	15 min	☑	☑
10	- Level 3 Enhanced	W7076	15 min	☑	☑
11	- Licensed Older Adult Day Services	W7094	15 min	☑	☑
	Prevocational Services				
12	- Base Staff Support no less than 1:15	W7087	15 min	☐	☐
13	- Staff Support Level 1 of <1:15 to 1:7.5	W7088	15 min	☐	☐
14	- Staff Support Level 2 of <1:7.5 to >1:1	W7089	15 min	☐	☐
15	- Staff Support Level 3 of 1:1	W7090	15 min	☐	☐
16	- Level 3 Enhanced	W7091	15 min	☐	☐

CERTIFICATION PAGE – SERVICE SELECTION

		Codes	Bill Unit	Waiver	Base
	Residential Habilitation - Licensed				
17	- Child Residential Services - Eligible	W7097	1/2 month	☐	☐
18	- Child Residential Services - Ineligible	W7098	1/2 month		☐
19	- Community Residential Rehab for the Mentally Ill - Eligible	W7202	1/2 month	☐	☐
20	- Community Residential Rehab for the Mentally Ill - Ineligible	W7203	1/2 month		☐
21	- Community Home for Mental Retardation - Eligible	W7220	1/2 month	☐	☐
22	- Community Home for Mental Retardation - Ineligible	W7221	1/2 month		☐
	Residential Habilitation - Unlicensed				
23	- Unlicensed Community Residential - Eligible	W7226	1/2 month	☐	☐
24	- Unlicensed Community Residential - Ineligible	W7227	1/2 month		☐
25	Supported Employment	W7235	15 min	☐	☐
	Transitional Work Service				
26	- Base Staff Support no less than 1:6	W7237	15 min	☐	☐
27	- Staff Support Level 1 of <1:6 to 1:3.5	W7239	15 min	☐	☐
28	- Staff Support Level 2 of <1:3.5 to >1:1	W7241	15 min	☐	☐
29	- Staff Support Level 3 of 1:1	W7243	15 min	☐	☐
30	- Level 3 Enhanced	W7245	15 min	☐	☐

CERTIFICATION PAGE – SERVICE SELECTION

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

CERTIFICATION PAGE – SERVICE SELECTION

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

Commonwealth of Pennsylvania
Office of Developmental Programs
Cost Report for the Mental Retardation Program

DRAFT

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
	DIRECT CARE EXPENSES	**Total Provider Expenses**	**Excluded Sites Expenses**	**Other LOB Expenses**	**Base Expenses**	**Residential Occupancy Expenses**	**Excluded Non-Allowable Waiver Expenses**	**Allowable Waiver 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)							

Commonwealth of Pennsylvania
Office of Developmental Programs
Cost Report for the Mental Retardation Program

DRAFT

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

SCHEDULE A – EXPENSE REPORT (Waiver)

		H	I	J	K	L	M	N
		Home and Community Based Services W7057 - Base Staff Support no less than 1:6 15 min	Home and Community Based Services W7058 - Staff Support Level 1 of <1:6 to 1:3.5 15 min	Home and Community Based Services W7059 - Staff Support Level 2 of <1:3.5 to >1:1 15 min	Home and Community Based Services W7060 - Staff Support Level 3 of 1:1 15 min	Home and Community Based Services W7061 - Level 3 Enhanced 15 min	Licensed Day Services W7072 - Base Staff Support no less than 1:6 15 min	Licensed Day Services W7073 - Staff Support Level 1 of <1:6 to 1:3.5 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							
23	Type of Unit (15 Min., Daily, etc.)	15 min	15 min	15 min	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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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 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.)	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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DRAFT

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
						Home and Community Based Services W7057	Home and Community Based Services W7058	Home and Community Based Services W7059
						- 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
	DIRECT CARE EXPENSES	Base Expenses	Base Non Waiver, Excluding Room & Board Expenses	Excluded Non-Allowable Expenses	Allowable Base Expenses	15 min	15 min	15 min
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)					$ -	$ -	$ -

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Office of Developmental Programs
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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 - Staff Support Level 3 of 1:1 15 min	Home and Community Based Services W7061 - Level 3 Enhanced 15 min	Licensed Day Services W7072 - Base Staff Support no less than 1:6 15 min	Licensed Day Services W7073 - Staff Support Level 1 of <1:6 to 1:3.5 15 min	Licensed Day Services W7074 - Staff Support Level 2 of <1:3.5 to >1:1 15 min	Licensed Day Services W7075 - Staff Support Level 3 of 1:1 15 min	Licensed Day Services W7076 - Level 3 Enhanced 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							
23	Type of Unit (15 Min., Daily, etc.)	15 min	15 min	15 min	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)	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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 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							
23	Type of Unit (15 Min., Daily, etc.)	15 min						
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 then 5% of total revenue)		
	Contributions :		
	United Way :		
8	Contributions not Restricted / Appropriated		
9	Restricted / Appropriated Contributions		
	Other (please describe):		
	Contributions not Restricted / Appropriated		
10			
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**	1 $ -	2 $ -

24	**NET INCOME (LOSS)**	$ -	$ -

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**	$ -	
	Add:		
20	TOTAL REVENUE from Schedule B		
21			
22			
23			
	Deduct:		
24	TOTAL EXPENSES from Schedule A		
25			
26			
27			
28	**TOTAL EQUITY OR FUND BALANCE END OF PERIOD**	$ -	$ -

1 - Should equal Schedule E, B-74

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

SCHEDULE D – DIRECT CARE STAFFING EXPENSES

	DIRECT CARE STAFF	A	B	C	ERE D	ERE E	ERE F	ERE G	ERE H	I	J
	Position	Credentials, Licensure, 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	RN							$ -		
2	Direct Care Staff, Full Time	MSN							$ -		
3	Direct Care Staff, Full Time	Other							$ -		
4	Direct Care Staff, Part Time								$ -		
5	Other (Specify)								$ -		
6	Other (Specify)								$ -		
7	Other (Specify)								$ -		
8	**Total**		1 $ -	2 $ -	$ -	$ -	$ -	$ -	3 $ -	-	-

	DIRECT CARE CONTRACTED STAFF	A	B	C	ERE D	ERE E	ERE F	ERE G	ERE H	I	J
	Position	Credentials, Licensure, 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	RN									
10	Direct Care Contracted Staff, Full Time	MSN									
11	Direct Care Contracted Staff, Full Time	Other									
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

DRAFT

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	A	B	C	ERE D	ERE E	ERE F	ERE G	ERE H	I	J	K
	Position	Credentials, Licensure, 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	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**		$ -	$ -	$ -	$ -	$ -	$ -	$ -	1 $ -	-	-

	INDIRECT CONTRACTED STAFF	A	B	C	ERE D	ERE E	ERE F	ERE G	ERE H	I	J	K
	Position	Credentials, Licensure, or Degree	Provider Fees	Waiver Fees	Health Benefits	Retirement Plan	Other Benefits	Payroll Taxes	Total Waiver ERE	Total Waiver Fees	Provider Total Hours	Waiver Total Hours
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**		$ -	$ -						2 $ -	-	-

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

SCHEDULE D-2 – ADMINISTRATIVE STAFFING EXPENSES

	ADMINISTRATIVE STAFF	A	B	C	ERE D	ERE E	ERE F	ERE G	ERE H	I	J	K
	Position	Credentials, Licensure, 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] $ -	-	-

1 - Should equal Schedule A, G-14

SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

	A	B	C	D	E	F
OCCUPANCY/BUILDINGS:	**Year Acquired**	**Original Cost**	**Depreciation Recorded Prior Years**	**Deprec. Method**	**Annual Rate**	**Depreciation Expense**
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**		$ -	$ -			$ -

SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

		A	B	C	D	E	F
	MOTOR VEHICLES:	**Year Acquired**	**Original Cost**	**Depreciation Recorded Prior Year**	**Deprec. Method**	**Annual Rate**	**Depreciation Expense**
	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**		$ -	$ -			$ -

SCHEDULE E – PROVIDER DEPRECIATION AND AMORTIZATION EXPENSES

		A	B	C	D	E	F
	FIXED ASSETS/EQUIPMENT:	**Year Acquired**	**Original Cost**	**Depreciation Recorded Prior Year**	**Deprec. Method**	**Annual Rate**	**Depreciation Expense**
	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)**	$ -	$ -			$ - [1]

1 - Should equal Schedule A, A-17

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PROVIDER NAME: ABC Company
MPI NO.: 123456789
PERIOD OF REPORT: 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 then 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] $ -

1 - Should equal Schedule A, G-16

SCHEDULE G – RELATED PARTY TRANSACTIONS

1. Is any property being leased from a party "related to provider" using the definitions in the cost report instructions?

   Yes _____ No _____

2. SCHEDULE OF LESSOR'S EXPENSES :

   If answer to number 1 is yes, provide lessor's costs in the space below.

Depreciation on property	_____
Property taxes	_____
Mortgage interest on property	_____
Insurance	_____
Other (describe)	_____
	_____
	_____
TOTAL	$ -

3. Are there any other related party transactions?

   Yes _____ No _____

   If yes, please describe financial terms below.

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.

		YES	NO
3.	Do you have accounting workpapers available to support direct expense allocations?		
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: