STATE OF CALIFORNIA
DEPARTMENT OF HEALTH SERVICES
MEDI-CAL PROGRAM COST REPORT

INTERMEDIATE CARE FACILITY
FOR THE DEVELOPMENTALLY DISABLED
HABILITATIVE/NURSING HOME OFFICE
COST REPORT

Home Office Name:_____

Reporting Period: From _____ To _____

SCHEDULE 1—HOME OFFICE COST REPORT
GENERAL INFORMATION

1. Home Office Name			3. Phone Number
2. Street Address	City	State	ZIP Code
4. Cost Reporting Period From: To:	5. Report Contact Person Name		Phone Number

6. Type of Chain Organization

❒ Nonprofit
- ❒ Corporation
- ❒ Church Affiliated
- ❒ Other (Specify) _____

❒ For profit
- ❒ Corporation
- ❒ Partnership
- ❒ Other (Specify) _____

7. Key Officers

President _____

Vice President(s) _____

_____

Secretary _____

Treasurer _____

Controller _____

8.

CERTIFICATION

I, _____, certify under penalty of perjury as follows:

That I am an official of _____ and am duly authorized to sign this certification and that to the best of my knowledge and information, I believe each statement and amount in the accompanying report to be true, correct, and in compliance with Section 14161 of the California Welfare and Institutions Code.

Signature _____ Date _____

Title _____

Address _____

Please be advised that continued submission of claims or cost reports for items or services which were not provided as claimed, are not reimbursable under the Medi-Cal program, or claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with the Welfare and Institutions Code, Section 14123.2.

9. Email a PDF signed copy to: ICFDDHN.Submissions@dhcs.ca.gov. For assistance/questions, contact ARAS at ICFDDHN.Questions@dhcs.ca.gov or (916) 650-6696.

Is this report being filed as a result of change in ownership? ❒ Yes ❒ No

Home Office Name	Fiscal Year End

SCHEDULE 2—STATEMENT OF REIMBURSABLE COSTS

(1) Account Description	(2) Expenses Per Home Office Books	(3) Adjustments Increase (Schedule 3, Column 3)	(4) Allowable Expenses (Column 2 +/– Column 3)	(5) Direct Allocations (Schedule 4, Line 11)	(6) Pooled Costs (Column 4 – Column 5)
1. Salaries—Officers					
2. Salaries—Other					
3. Payroll Taxes					
4. Employee Benefits					
5. Travel					
6. Entertainment					
7. Automobile					
8. Depreciation—Building					
9. Depreciation—Equipment					
10. Other Depreciation & Amortization					
11. Leases and Rentals					
12. Interest—Mortgages					
13. Interest—Other					
14. Taxes and Licenses					
15. Legal and Accounting					
16. Insurance					
17. Telephone					
18. Utilities					
19. Office Supplies					
20. Nonprogram					
21. Other (Specify)					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					
31.					
32.					
33.					
34.					
35. TOTAL					*

* To Schedule 5

Home Office Name	Fiscal Year End

SCHEDULE 3—MEDI-CAL ADJUSTMENTS TO EXPENSES

(1) Description	(2) Basis of Adjustment*	(3) Amount	(4) Line Number	(5) Account to be Adjusted (Schedule 2, Column 1) Account Name
1. Penalties				
2. Donations				
3. Gain/Loss on Asset Disposal				
4. Life Insurance Premium—Corporation Benefits				
5. Bad Debts				
6. Fund-Raising Expense				
7. Rebates/Refunds				
8. Interest Income				
9. Nonclient Care Related				
10. Other (Specify)				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21. TOTAL				

(To Schedule 2, Column 3)

* The Basis for the Adjustment is either A or B.
A = Cost
B = Revenue (Cost Recovery Items)

Home Office Name	Fiscal Year End

SCHEDULE 4—DIRECT ALLOCATION OF EXPENSES TO CHAIN COMPONENTS

(1)	(2)	(3)	(4)	(5)	(6)	(7)
	Expenses Directly Allocable to Chain Component					
	(Specify Type of Expense)					
Facility (Chain Component)	A	B	C	D	E	Total** F
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11. TOTAL*						

* Transfer amount(s) on Line 11 to Schedule 2, Column 5.
** Transfer Column 7 amount(s) to Schedule 6, Column 3.

Home Office Name	Fiscal Year End

SCHEDULE 5—ALLOCATION OF POOLED EXPENSES

PART I—ALLOCATION BETWEEN PROVIDER AND NONPROVIDER COMPONENTS
(Complete only if double allocation method is used)

Facility	(1) Allocation Statistics Base: Accumulated Cost	(2) Percent	(3) Allocation Pool Expenses
1. Program Services			(A)
2. Nonprogram Services			
3. TOTAL		100%	*

PART II—ALLOCATION TO INDIVIDUAL CHAIN COMPONENTS
(Complete if single *OR* double allocation method is used)

(1) Facility	(2) Allocation Statistics (Client Days)	(3) Allocation Pooled Expenses**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11. TOTAL	(B)	*(A)
12. Unit Cost Multiplier (A /B)		

* From Schedule 2, Line 35, Column 6.
** Transfer Allocated pool expenses to Schedule 6, Column 4.

Home Office Name	Fiscal Year End

SCHEDULE 6—SUMMARY OF DIRECT AND ALLOCATED POOL COST

(1) Facility	(2) Medi-Cal Provider Number	(3) Home Office Expenses Directly to Facility*	(4) Allocated Pool Expenses**	(5) Total Direct and Pool Facility Expense (Column 3 + Column 4)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11. TOTAL				

* From Schedule 4, Column 7.
** From Schedule 5, Part II, Column 3.