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

INTERMEDIATE CARE FACILITY
FOR THE DEVELOPMENTALLY DISABLED

Facility Name: _____

Service Level: ☐ **Habilitative** ☐ **Nursing**

NPI Number: _____

Reporting Period: From _____ To _____

INTERMEDIATE CARE FACILITY COST REPORT FOR THE DEVELOPMENTALLY DISABLED (HABILITATIVE OR NURSING) GENERAL INFORMATION AND CERTIFICATION

1. Name of Facility	2. State License Number	3. NPI Number
4. Street Address	5. City	6. ZIP Code
7. Mailing Address	8. City	9. ZIP Code

10. Administrator

11. Report Contact Person	12. E-mail Address	13. Phone Number
14. Mailing Address: Street or P.O. Box	15. City	16. ZIP Code
17. Reporting Period Began	18. Reporting Period End	
19. Name of Home Office (If Applicable)		20. Home Office Phone Number

21.

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.

22. 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

NOTE: A COMPLETED REPORT IS REQUIRED FOR EACH LICENSED FACILITY

Facility Name	Fiscal Year End

SECTION A—REQUEST FOR INFORMATION

1. Are financial statements (income statement, balance sheet, etc.) available for the cost reporting period? ☐ Yes ☐ No
2. Were any assets disposed of during the reporting period? ☐ Yes ☐ No
3. Does your facility maintain patient trust accounts? ☐ Yes ☐ No

If yes:

a. Balance of trust account at the beginning of period . . . . . .$_____

b. Total deposits during reporting period . . . . . .$_____

c. Total expenditures from trust account. . . . . .$_____

d. Balance at the end of reporting period . . . . . .$_____

SECTION B—LICENSEE DESCRIPTION

	Type of Control	X	Legal Organization	X	
01	Church Related Not-For-Profit		Corporation		07
02	Other Not-For-Profit		Division of a Corporation		08
03	Investor Owned For-Profit		Partnership		09
04	Owner/Operator For-Profit		Proprietorship		10
05			Other (Specify)		11

SECTION C—FACILITY CENSUS

Line	Total Statistics	Medi-Cal Fee for Service	Medi-Cal Managed Care	Other	Total
1	Licensed Beds—Beginning of Period				
2	Licensed Beds—End of Period				
3	Client Days				0
4	Discharges Including Deaths				0
5	Admissions				0

Facility Name	Fiscal Year End

SECTION D—STATEMENT OF RELATED ORGANIZATIONS

Is the facility part of a chain organization? (For definition, see Section E instructions.) ☐ Yes ☐ No

If yes, please complete the following:

Home Office or Related Organization	Percent of Ownership

SECTION E—STATEMENT OF HOME OFFICE COSTS

Are any costs included during this reporting period a result of transactions with the home office (parent company)? If yes, you are required to file a home office cost report (See instructions). Please provide the information which is the result of transactions with a related organization. ☐ Yes ☐ No

Account	Item	Amount
		$

SECTION F—STATEMENT OF COMPENSATION TO OWNERS

Name of Owners	If Employed by Facility: Title and Function	Owners Investment Percentage	Average Hours Worked Per Week	Compensation	
				Current Fiscal Year	Prior Fiscal Year
		0.00%		$	$
		0.00%			
		0.00%			
		0.00%			

SECTION G—STATEMENT OF COMPENSATION PAID TO ADMINISTRATOR (OTHER THAN OWNERS OR QMRP)

Name	Title	Weekly Average Hours Devoted To Facility	Compensation	
			Current Fiscal Year	Prior Fiscal Year
			$	$

SECTION H—STATEMENT OF INCOME AND EXPENSE WITH RECLASSIFICATION AND ADJUSTMENTS

Line Number	(1) Description	Account Number	(2) Amount	(3)* Reclassification and Adjustments	(4) Total Amount (Col. 2 & 3)
	Revenues: Client Services:				
005	Medi-Cal Per Diem	4010	$	$	$ 0
006	Adult Day Services & Related Transportation				0
010	Private	4020			0
015	Other	4030			0
020	Subtotal (Lines 005 to 015)		0	0	0
	Deductions From Revenue:				
025	Contractual and Other Deductions	4040			0
030	Net Client Service Revenue (Line 020 – 025)		0	0	0
035	Other Operating Revenue	4050			0
040	Net Operating Revenue (Line 030 + 035)		0	0	0
	Expenses: Client Services				
	Basic Facility Cost				
	Property Expenses:				
045	Depreciation and Amortization	5010			0
050	Leases and Rentals	5020			0
055	Real Property Taxes	5030			0
060	Personal Property Taxes	5040			0
065	Mortgage Interest	5050			0
070	Property Insurance	5060			0
075	Total Property Expenses (Lines 045 to 070)		0	0	0
	General Home Expenses:				
080	Home Operations and Maintenance	5070			0
085	Utilities	5080			0
090	Client Transportation (excluding Adult Day Services)	5090			0
095	Dietary	6000			0
100	Personal Care and Laundry	6010			0
105	Total General Home Expenses (Lines 080 to 100)		0	0	0
110	Total Basic Facility Cost (Line 075 + 105)		$ 0	$ 0	$ 0

* From Page 5, Column 1.

Facility Name	Fiscal Year End

SECTION H—STATEMENT OF INCOME AND EXPENSE WITH RECLASSIFICATION AND ADJUSTMENTS (Continued)

Line Number	(1) Description	Account Number	(2) Amount	(3)* Reclassification and Adjustments	(4) Total Amount (Col. 2 & 3)
	Direct Care Staff Costs:				
115	QMRP Salaries	6020	$	$	$ 0
120	QMRP Fringe Benefits	6025			0
125	Lead Salaries	6030			0
130	Lead Benefits	6035			0
135	Aides Salaries	6040			0
140	Aides Benefits	6045			0
145	Other Salaries	6050			0
150	Other Benefits	6055			0
155	Total Client Care Staff Cost (Lines 115 to 150)		0	0	0
	Consultant Costs:				
160	Dietitian Consultant	6060			0
165	Speech Pathology Consultant	6070			0
170	Physical Therapy Consultant	6080			0
175	Occupational Therapy Consultant	6090			0
180	Pharmacist Consultant	7000			0
185	Nurse Consultant	7010			0
190	Psychologist Consultant	7020			0
195	Physician Consultant	7030			0
200	Recreational Consultant	7040			0
205	Social Service Consultant	7050			0
210	Other Consultant	7060			0
215	Total Consultant Cost (Lines 160 to 210)		0	0	0
	Administrative Costs:				
220	Administrative Salaries**	7070			0
225	Administrative Fringe Benefits	7075			0
226	Quality Assurance Fees (excluding Adult Day Services)	7080			0
230	Other General and Administrative*** (excluding Adult Day Services)	7080			0
235	Total Administrative Cost (Lines 220 to 230)		0	0	0
	Non-client Care Expense:				
240	Non-program Services	7090			0
241	Adult Day Services & Related Transportation				0
245	Total Expenses (Lines 110, 155, 215, 235, 240, 241)		0	0	0
250	NET INCOME (Line 040 – 245)		$ 0	$ 0	$ 0

* From Page 5, Column 1.
** List only direct administrative salaries incurred at the facility level
*** List allocated administrative costs on Line 230

Facility Name	Fiscal Year End

SECTION I—RECLASSIFICATION AND ADJUSTMENTS OF REVENUES AND EXPENSES

Line	Account Description	(1) Amount Increase (Decrease)	(2) Statement of Income Line Number	(3) Explanation of Reclassification of Adjustment
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	TOTAL	$ 0		

AMOUNTS TO BE TRANSFERRED: Transfer all entries from Column 1 to Page 4 or 4.1, Column 3.

BASIS FOR RECLASSIFICATIONS AND ADJUSTMENTS: It is necessary to analyze some accounts in order to ensure that various items and amounts are properly classified in order to effect a proper cost distribution. Please refer to instructions.

SECTION J—LABOR REPORT

Number	Description	(1) Benefits	(2) Salaries	(3) Total Hours	(4) Average Hourly Wage
1	QMRP	$	$ 0	0.00	$ 0.00
2	Lead		0	0.00	0.00
3	Aides		0	0.00	0.00
4	Other Salaries			0.00	0.00
5	Subtotal (Lines 1 to 4)	0	0	0.00	0.00
	CONSULTANT COSTS:				
6	Dietitian Consultant				
7	Speech Pathology Consultant				
8	Physical Therapy Consultant				
9	Occupational Therapy Consultant				
10	Pharmacist Consultant				
11	Nurse Consultant				
12	Psychologist Consultant				
13	Physician Consultant				
14	Recreational Consultant				
15	Social Service Consultant				
16	Other Consultant				
17	Subtotal (Lines 6 to 16)	0	0	0.00	
	ADMINISTRATIVE COSTS*				
18	Administrative Salaries*				
19	GRAND TOTAL (Lines 5, 17, & 18)	$ 0	$ 0	0.00	$

* List only direct administrative costs. Do not include home office administrative cost.