

SUPPLEMENTAL COST REPORT SCHEDULE B
 FOR
 INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED
 (HABILITATIVE OR NURSING)
 ADULT DAY SERVICES AND RELATED TRANSPORTATION COST

INCOMPLETE, INACCURATE OR ALTERED SCHEDULES WILL NOT BE ACCEPTED

Provider Name: _____

Medi-Cal National Provider Identifier (NPI): _____

Fiscal Period Year: _____

Reporting Period Begin Date: _____

Reporting Period End Date: _____

Contact Person: _____

Mailing Address: _____

Phone: _____

Date Submitted: _____

Title: _____

E-mail Address: _____

Line 1 Adult Day Services Medi-Cal Participant Days _____

Line 2 Adult Day Services Revenue \$ _____

Line 3 Direct Costs* \$ _____

Line 4 Regional Center's Administrative Cost** \$ _____

Line 5 ICF/DDs Administrative Costs*** \$ _____

Line 6 Quality Assurance Fees Associated with Adult Day Services**** \$ _____

Line 7 Total Adult Day Services Cost \$ _____

(note: the cost should match revenue)

*Direct costs of providing the day program treatment and transportation costs

**Regional Center's administrative costs in making disbursements on behalf of the ICF/DD's provider for these services

***ICF/DD's administrative costs for staff responsible for performing the duties related to Adult Day Services

****Quality Assurance fee paid associated with Adult Day Services and related transportation