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				
4	Discharges Including Deaths				
5	Admissions				

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
				$	$

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
			$	$

Facility Name	Fiscal Year End

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

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

* 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	$		

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.

Facility Name	Fiscal Year End

SECTION J—LABOR REPORT

Number	Description	(1) Benefits	(2) Salaries	(3) Total Hours	(4) Average Hourly Wage
1	QMRP	$	$		$
2	Lead				
3	Aides				
4	Other Salaries				
5	Subtotal (Lines 1 to 4)				
	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)				
	ADMINISTRATIVE COSTS*				
18	Administrative Salaries*				
19	GRAND TOTAL (Lines 5, 17, & 18)	$	$		$

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