

State of Louisiana
Department of Health and Hospitals
HCBS Cost Report

INSTRUCTIONS FOR FILING:

I **Within 90 days of cost report period end, e-mail** the following documentation to Myers and Stauffer.

Required Items (Must be submitted with your filing)

Note: Use numbering below to number your attachment files as indicated (e.g., the Central Office working trial balance would be numbered "8")

HCBS Documentation

1. Signed and dated Certification Page of the Louisiana Medicaid HCBA Cost Report
2. Electronic copy of completed Louisiana Medicaid HCBS cost report in Excel.
3. Working trial balance used to prepare the cost report.
4. Detailed asset listing including full depreciation schedule as of the cost report period end.
5. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)

Central Office Documentation

6. Signed and dated Certification Page of the Louisiana Medicaid HCBS Central Office Cost Report.
7. Electronic copy of completed Louisiana Medicaid HCBS cost report in Excel.
8. Working trial balance used to prepare the cost report.
9. Detailed asset listing including full depreciation schedule as of the cost report period end.
10. Copy of all lease and loan agreements and any amortization schedules (*if applicable*)

II Electronic Files Should be Named in the following example formats (all files should be in .pdf except for the cost report which must be an Excel file):

Medicaid Cost Report File (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "Cost Report"):

99999 CO group name - Facility name - 20090630 Cost Report.xls

If You Have One Attachment File (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + "CR Attachments"):

99999 CO group name - Facility name - 20090630 CR Attachments.pdf

If You Have Multiple Attachment Files (provider # + Central Office Name + Facility Name + Year End in "yyyymmdd" format + Description + Number Sequence from above list):

99999 CO group name - Facility name - 20090630 Depr Sched - 4.pdf

99999 CO group name - Facility name - 20090630 WTB - 3.pdf

etc....

All electronic documentation should be e-mailed to Myers and Stauffer at:

All paper documentation can be mailed (using certified or other traceable delivery) or faxed to:

III Make a back-up copy of your electronic cost report and retain for future reference.

For Versions of Excel prior to 2007, there is a toolbar that includes buttons for Auditor, Add Row, Delete Extra Rows, Print, and For Office 2007 (new version), Auditor, Add Row, Delete Extra Rows, Print, and Instructions toolbar buttons will show under the "Add If the custom toolbar buttons (Auditor, Add Row, Delete Extra Rows, Print, & Instructions) are not present, as described above, <http://office.microsoft.com/en-us/excel/HA011189901033.aspx> <http://office.microsoft.com/en-us/excel/HP100969191033.aspx>

[CLICK HERE TO READ THE INSTRUCTIONS PRIOR TO COMPLETING THE COST REPORT](#)

HCBS Version 1.0 11/03/2011

**STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS
COST REPORT FOR HCBS PROVIDERS**

Schedule A - Facility Information

COST REPORT PERIOD FROM: TO:

DATE COMPLETED:

CORPORATE NAME:

FACILITY NAME:

MAILING ADDRESS:

MAILING ADDRESS:

MAILING CITY: STATE: ZIP:

FACILITY ADDRESS:

STREET ADDRESS:

CITY: STATE: ZIP:

CONTACT PERSON: PHONE: EXT:

FAX: EXT:

E-MAIL:

TYPE OF FACILITY

HCBS Vendor Number

TYPE OF CONTROL (Select only one)

Nonprofit

- 1. Church Related
- 2. Private
- 3. Other (specify)

Proprietary

- 1. Individual
- 2. Partnership
- 3. Corporation

Governmental

- 1. State
- 2. Parish
- 3. City
- 4. City-Parish
- 5. Other (specify)

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE B - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

1. List all owners with 5% interest or more (even if they receive no compensation) or Board of Directors and relatives of owners or Board of Directors employed by the provider.

<u>Name</u>	<u>Function</u>	<u>% of Work Week Devoted to Business</u>	<u>% of Ownership</u>	<u>Compensation Included in Allowable Cost for This Period</u>
John Smith	President/Administrator	100.00%	0.00%	0
Mary Smith	VP/Social Worker	25.00%	0.00%	5,000
Jane Doe	Board Member	0.00%	0.00%	0
Susan Jones	Board Member	0.00%	0.00%	0

2. Changes in Ownership, Licensure, or Certification During Cost Report Period

<u>Type of Change</u>	<u>From</u>	<u>To</u>	<u>Date of Change</u>
None			

3. If the facility or any equipment is leased, give name(s) of owners(s) of leased asset(s), owner's relationship to the facility and terms of the lease. (Attach a copy of the executed lease agreements(s) effective during the cost report period).

<u>Owner of Leased Assets</u>	<u>Relationship to Facility</u>	<u>Payments / Term</u>
GMAC	None	300/mo
James Smith	John Smith's Brother	1000/mo
John Smith	President	1000/mo

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE B - OWNER AND RELATED ORGANIZATION

(COST REPORT IS NOT COMPLETE WITHOUT THIS INFORMATION)

4. In the amount of cost reported, are any costs included which are a result of transactions with related parties or organizations as defined in the Medicare Provider Reimbursement Manual (HIM-15)?

Yes If "Yes", complete parts a. & b.

a. List costs incurred as a result of transactions with related parties or organizations.

Schedule H - Part	Line Item No. & Line Item Title	Amount Reported
D	3b Leased - Other Building	\$ 12,000
D	1a Buildings	4,000
D	2 Interest - Mortgage on Building or Equipment	3,000
D	4 Property Taxes	400
D	5 Insurance - Property	1,500
C	33a Shared Cost (Allocated)*	31,376
D	8a Shared Cost (Allocated)*	3,469
C	33b Shared Cost (Allocated)*	15,376
D	8b Shared Cost (Allocated)*	2,654
A	18a Allocated (Related Party)	52,037

b. List name(s) of related parties or organizations and relationship to facility.

Name of Related Party	Name of Related Organizations	Relationship
James Smith	James Smith - Lessor	Brother of Administrator
XYZ Corporation	Central Office	Common Board
XYZ Corporation	Regional Office	Common Board
Work Program, Inc.	Habilitation program	Common Owner

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE C - STAFF AND OTHER INFORMATION

1. Total number of employees for last payroll	10.0
2. Number of Minimum Wage Employees	3.0
3. Position Summary	<u>Full Time Equivalent</u>
a. Direct Care	7.50
b. Care Related	0.00
c. Administrative and Operating	0.00
Total Full Time Equivalent (a. + b. + c.)	7.50

4. Fringe Benefits Provided

- a. Life Insurance
- b. Health Insurance
- c. Retirement Plan
- d. Uniforms
- e. Meals
- f. Other (Describe)
- g. Other (Describe)
- h. Other (Describe)
- i. None

5. Number of vehicles owned or leased by facility	1
6. Number of mortgages on fixed assets	1

	Original Date	Amount	Interest Rate	Amortization Period
a. First Mortgage	4/1/2005	12,000	6.00%	5
b. Second Mortgage				
c. Third Mortgage				

7. Other rates received	
a. Private client rate	200.00
b. Other state or federal rates	
c. Other (specify)	

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: FROM 1/0/1900 TO 1/0/1900

SCHEDULE E - BALANCE SHEET

ASSETS		
<u>ACCOUNTS</u>		<u>PER BOOKS</u>
Current Assets:		
1. Cash on Hand and in Banks		20,000
2. Accounts Receivable		45,000
3. Notes Receivable		
4. Other Receivables		
5. Receivable		
6. Inventory		
7. Prepaid Expenses		2,000
8. Investment		
9. Other (specify):		
10. Total Current Assets		\$ 67,000
Fixed Assets:		
11. Land		5,000
12. Buildings		
13. Less: Accumulated Depreciation		
14. Leasehold Improvements		20,000
15. Less: Accumulated Depreciation		(2,000)
16. Fixed Equipment		6,000
17. Less: Accumulated Depreciation		(500)
18. Major Movable Equipment		4,000
19. Less: Accumulated Depreciation		(3,500)
20. Motor Vehicles		40,000
21. Less: Accumulated Depreciation		(12,000)
22. Minor Equipment (non-depreciable)		
23. Total Fixed Assets		\$ 57,000
Other Assets:		
24. Investments		
25. Deposits on Leases or Utilities		250
26. Due from Owners/Officers		
27. Dues to Funds		
28. Other (specify):		
29. Total Other Assets		\$ 250
30. TOTAL ASSETS (sum of lines 10, 23 & 29)		\$ 124,250

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: FROM 1/0/1900 TO 1/0/1900

SCHEDULE E - BALANCE SHEET

LIABILITIES AND CAPITAL

<u>ACCOUNTS</u>	<u>PER BOOKS</u>
Current Liabilities	
31. Accounts Payable	35,000
32. Notes Payable	
33. Current Portion of Long-term Debt	
34. Salaries-Fees Payable	3,200
35. Payroll Taxes Payable	300
36. Deferred Income	
37. Other (specify): <u>Accrued Bonuses</u>	2,000
38. Total Current Liabilities	\$ 40,500
Long-Term Liabilities	
39. Mortgages Payable	
40. Notes Payable	7,000
41. Unsecured Loans	
42. Loans from Owners	
43. Total Long-Term Liabilities	\$ 7,000
44. TOTAL LIABILITIES (sum of lines 38 and 43)	\$ 47,500
Capital	
45. Capital	
(a) Retained Earnings	76,750
(b) Capital Stock	
(c) Other (specify)	
(d) Other (specify)	
(e) Other (specify)	
(f) Other (specify)	
(g) Other (specify)	
46. Total Capital	\$ 76,750
47. TOTAL LIABILITIES AND CAPITAL (sum of lines 44 and 46)	\$ 124,250

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE F - INCOME STATEMENT SCHEDULE

	(a)	(b)	(c)
	Income per Books	Provider Adjustments <i>(from Schedule I)</i>	Adjusted Balance
Routine Service Income:			
1 Medicare - Routine		-	\$ -
2 SSI/SSA - Routine		-	\$ -
3a Medicaid - State - Routine	400,000	-	\$ 400,000
3b N/A		-	\$ -
4 Other State Revenue - Routine		-	\$ -
5 Private - Routine	30,000	-	\$ 30,000
6a Grants - Federal*		-	\$ -
6b Grants - State*	Food	-	\$ -
7 Other (specify)		-	\$ -
8 Total Routine Service Income	430,000	-	430,000
Other Income:			
9 Special expense reimbursement (state clients)		-	\$ -
10a Donations - Restricted		-	\$ -
10b Donations - Unrestricted		-	\$ -
11 Sale of Drugs		-	\$ -
12 Therapy		-	\$ -
13 Sale of Supplies		-	\$ -
14 Employee and Guest Meals		-	\$ -
15 Interest	75	-	\$ 75
16 Rentals		-	\$ -
17 Beauty and Barber Shop		-	\$ -
18 Vending Machine		-	\$ -
19a Miscellaneous (specify)	Workers' Comp Refunds	400	\$ 400
19b Miscellaneous (specify)	Copies of Med Files	20	\$ (20)
19c Miscellaneous (specify)		-	\$ -
19d Miscellaneous (specify)		-	\$ -
19e Miscellaneous (specify)		-	\$ -
20 Total Other Income	495	(20)	\$ 475
21 Total Income (line 8 and 20)	430,495	(20)	430,475
Less Refunds and Allowances**			
22 Medicare - Refunds an Allowances		-	\$ -
23 SSI/SSA - Refunds and Allowances		-	\$ -
24 Medicaid - Refunds and Allowances		-	\$ -
25 Other State Revenue - Refunds and Allowances		-	\$ -
26 Private - Refunds and Allowances		-	\$ -
27 Other (specify)		-	\$ -
28 Total Refunds and Allowances	-	-	\$ -
29 Net Income (line 21 minus 28)	430,495	(20)	430,475

*State type grant, period covered; if more than one, provide separate listing.
 If grant is continuous or declining, state percentages or amounts.

**Indicate amount reimbursed or credited to DHH (if any).

VENDOR NUMBER: 0
FACILITY NAME: 0
COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE G - Expense Form Index

Please select all that apply:

<u>Number</u>	<u>Waiver Programs</u>	<u>Expense Form</u>
1.	Children's Choice Waiver	Children's EXP
2.	Supports Waiver	Supports EXP
3.		
4.		
5.		
6.		

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Children's Choice Waiver

STATISTICS

Total Clients

92

Code	Units of Service	Units Medicaid	Medicaid Rate per Unit	Units Other State	Rate per Unit Other State	Units Private Pay	Rate per Unit - Private Pay	Total Units	Total Income per Waiver
9E001	Support Coordination	2,268	\$ 125.00					2,268	\$ 283,500
H2011	Crisis Support		\$ 3.10					0	\$ -
S5125	Family Support	1,892	\$ 3.57					1,892	\$ 6,754
T1005	Center Based Respite		\$ 2.62					0	\$ -
S5111	Family Training							0	\$ -
T2028	Diapers							0	\$ -
S5165	Ramp-Home							0	\$ -
S5165	Bathroom Modifications							0	\$ -
S5165	General Adaptations							0	\$ -
T2039	Vehicle Lifts							0	\$ -
H2011	Crisis Support - 2 Children		\$ 2.32					0	\$ -
S5125	Family Support - 2 Children		\$ 2.56					0	\$ -
H2011	Crisis Support Center Based		\$ 2.32					0	\$ -
	Case Management	74	\$ 125.00					74	\$ 9,250
	PAS/Attend Care (1 person)	1,128	\$ 14.28					1,128	\$ 16,108
	PAS/Attend Care (2 person)		\$ 10.88					0	\$ -
	PAS/Attend Care (3 person)		\$ 9.44					0	\$ -
	Respite/Center	253	\$ 306.24					253	\$ 77,479
	Respite/In-home		\$ 12.76					0	\$ -
	PERS (install)		\$ -					0	\$ -
	PERS (Month)		\$ -					0	\$ -
	Transportation		\$ -					0	\$ -
	Transportation wheelchair		\$ -					0	\$ -
	RN consultation/Assessment		\$ -					0	\$ -
	LPN (in-home) (1 person)		\$ -					0	\$ -
	Speech Therapy		\$ -					0	\$ -
	OT		\$ -					0	\$ -
	PT		\$ -					0	\$ -
		5,615		0		0		5,615	\$ 393,091

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Children's Choice Waiver
EXPENSES

<u>Expense Classification</u>	(a) Expenses per Books	(b) Provider Adjustments <i>(from Schedule I)</i>	(c) Allowable Expenses
A. Direct Care Costs			
1 Salaries - Aides	256,879	-	\$ 256,879
2 Salaries - LPNs		-	\$ -
3 Salaries - RNs		-	\$ -
4 Salaries - Social Services	39,821	-	\$ 39,821
5 Salaries - Activities (excl. Act. Dir.)		-	\$ -
6 Salaries Therapist			\$ -
a. Physical Therapists			\$ -
b. Occupational Therapist			\$ -
c. Speech Therapist			\$ -
d. Respirational Therapist			\$ -
7 Payroll Taxes	21,362	-	\$ 21,362
8 Employee Benefits		-	\$ -
9 Workers' Compensation	12,549	-	\$ 12,549
10 Contract - Aides		-	\$ -
11 Contract - LPNs		-	\$ -
12 Contract - RNs		-	\$ -
13 Contract - Social Services (MSW)		-	\$ -
14 Contract Therapist			\$ -
a. Physical Therapists			\$ -
b. Occupational Therapist			\$ -
c. Speech Therapist			\$ -
d. Respirational Therapist			\$ -
15 Drugs - OTC & Non-Legend		-	\$ -
16 Medical Supplies		-	\$ -
17 Medical Waste Disposal		-	\$ -
18 Other Supplies		-	\$ -
19 a. Shared Costs (Allocated)* (Specify Source)	<i>Central Office Allocation Tab</i>	44,990	\$ 44,990
19 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
19 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
20 Allocated Costs - Hospital Based			\$ -
a. Miscellaneous (specify)		-	\$ -
b. Miscellaneous (specify)		-	\$ -
Total Direct Care Costs	\$ 330,611	\$ 44,990	\$ 375,601

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Children's Choice Waiver

B. Care Related Costs

1 Salaries - Supervisory Staff	66,843	-	\$ 66,843
2 Salaries - Dietary		-	\$ -
3 Payroll Taxes	5,080	-	\$ 5,080
4 Employee Benefits		-	\$ -
5 Workers' Compensation		-	\$ -
6 Consultant Fees			
a. Activities Consultant Fees		-	\$ -
b. Nursing Consultant Fees		-	\$ -
c. Pharmacy Consultant Fees		-	\$ -
d. Social Worker Consultant Fees		-	\$ -
7 Food-Raw		-	\$ -
8 Food-Supplements		-	\$ -
9 Supplies	964	20	\$ 984
10 Allocated Costs - Hospital Based		-	\$ -
11 a. Shared Costs (Allocated)* (Specify Source)	<i>Central Office Allocation Tab</i>	125,329	\$ 125,329
11 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
11 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
12 Miscellaneous (specify)		-	\$ -
Total Care Related Costs	\$ 72,887	\$ 125,349	\$ 198,236

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Children's Choice Waiver

C. Administrative and Operating Costs

1 Salaries and Wages - Administrator		-	\$ -
2 Salaries and Wages - Asst Administrator		-	\$ -
3 Salaries and Wages - Medical Director		-	\$ -
4 Salaries and Wages - Housekeeping		-	\$ -
5 Salaries and Wages - Laundry		-	\$ -
6 Salaries and Wages - Maintenance		-	\$ -
7 Salaries and Wages - Drivers		-	\$ -
8 Salaries and Wages - Other Administrative		-	\$ -
9 Salaries and Wages - Owner or Owner/Admin.	100,000	(100,000)	\$ -
10 Payroll Taxes		-	\$ -
11 Employee Benefits		-	\$ -
12 Workers' Compensation		-	\$ -
13 Contract - Dietary		-	\$ -
14 Contract - Housekeeping		-	\$ -
15 Contract - Laundry		-	\$ -
16 Contract - Maintenance		-	\$ -
17 Consultant Fees - Dietician		-	\$ -
18 Accounting Fees		-	\$ -
19 Amortization Expense Non-Capital		-	\$ -
20 Bank Service Charge		-	\$ -
21 Board of Directors' Fees		-	\$ -
22 Dietary Supplies		-	\$ -
23 Dues		-	\$ -
24 Educational Seminars and Training		-	\$ -
25 Housekeeping Supplies		-	\$ -
26 Insurance - Professional Liability and Other		-	\$ -
27 Interest on Non-Capital and Vehicles		-	\$ -
28 Laundry Supplies		-	\$ -
29 Legal Fees		-	\$ -
30 Linen Supplies		-	\$ -
31 Management Fees and Home Office Costs		-	\$ -
32 Non-Emergency Medical Transportation		-	\$ -
33 Office Supplies and Subscriptions		-	\$ -
34 Postage		-	\$ -
35 Repairs and Maintenance		-	\$ -
36 Taxes and License		-	\$ -
37 Telephone & Communications		-	\$ -
38 Travel		-	\$ -
39 Vehicle Expenses (Gas, Oil, etc..)		-	\$ -
40 Utilities		-	\$ -
41 Allocated Costs - Hospital Based		-	\$ -
42 Maintenance Supplies		-	\$ -
43 Advertising		-	\$ -
44 a. Shared Costs (Allocated)* (Specify Source)	Central Office Allocation Tab	19,208	\$ 19,208
44 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
44 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
45 Miscellaneous (specify)	Background Checks	983	\$ 983
Total Administrative and Operating Costs		\$ 100,983	\$ (80,792)
			\$ 20,191

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Children's Choice Waiver

D. Property and Equipment				
1	Depreciation Expense - (Provide detailed schedules)			
a.	Depreciation - Buildings		-	\$ -
b.	Depreciation - Furniture & Equipment		-	\$ -
c.	Depreciation - Motor Vehicles		-	\$ -
d.	Depreciation - Leasehold Improvements		-	\$ -
2	Interest Expense - Capital		-	\$ -
3	Property Insurance		-	\$ -
4	Property Taxes		-	\$ -
5	Rent - Building		-	\$ -
6	Rent - Furniture & Equipment		-	\$ -
7	Auto Lease		-	\$ -
8	Allocated Costs - Hospital		-	\$ -
9 a.	Shared Costs (Allocated)* (Specify Source)	Central Office Allocation Tab	4,480	\$ 4,480
9 b.	Shared Costs (Allocated)* (Specify Source)		-	\$ -
9 c.	Shared Costs (Allocated)* (Specify Source)		-	\$ -
10	Miscellaneous (specify)		-	\$ -
Total Property & Equipment			\$ -	\$ 4,480
Sum of Sections A, B, C and D			\$ 504,481	\$ 598,508

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Supports Waiver

STATISTICS

Total Clients

211

Code	Units of Service	Units Medicaid	Medicaid Rate per Unit	Units Other State	Average Rate per Unit - Other State	Units Private Pay	Average Rate per Unit - Private Pay	Total Units	Total Income per Waiver
H2024	Individual Job Self-Employment or Microenterprise Job Assessment, Discovery and Development		\$ 96.47	-				0	\$ -
H2024	Group Employment Job Assessment, Discovery and Development		\$ 80.70	-				0	\$ -
H2026	Individual Job, Self-Employment or Microenterprise Initial Job Support and Retention	78	\$ 48.24	-				78	\$ 3,763
H2026	Group Employment Initial Job Support and Retention One staff to one-two participant ratio		\$ 71.42	-				0	\$ -
H2026	Group Employment Initial Job Support and Retention One staff to one to three-four participant ratio		\$ 58.13	-				0	\$ -
H2026	Group Employment Initial Job Support and Retention One staff to one to five-eight participant ratio		\$ 43.50	-				0	\$ -
T2020	Day Habilitation One staff to one participant	325	\$ 76.53	-				325	\$ 24,872
T2020	Day Habilitation One staff to two-four participant ratio		\$ 60.29	-				0	\$ -
T2020	Day Habilitation One staff to five to eight participant ratio		\$ 43.60	-				0	\$ -
T2014	Prevocational services one staff to one participant ration	2,698	\$ 76.53	-				2,698	\$ 206,478
T2014	Prevocational services one staff to two to four participant ration		\$ 51.02	-				0	\$ -
T2014	Prevocational services one staff to five to eight participant ratio		\$ 34.32	-				0	\$ -
T1005	Center Based Respite			-				0	\$ -
S5125	In-home Respite	7,596	\$ 3.71	-				7,596	\$ 28,181
T2019	Habilitation		\$ 3.71	-				0	\$ -
Z0058	PERS Installation		\$ 30.00	-				0	\$ -
T2023	Support Coordination	1,098	\$ 155.00	-				1,098	\$ 170,190
Z0059	PERS Monthly maintenance		\$ 28.00	-				0	\$ -
	Case Management		\$ 155.00	-				0	\$ -
	PAS/Attend Care (1 person)	452	\$ 14.40	-				452	\$ 6,509
	PAS/Attend Care (2 person)		\$ -	-				0	\$ -
	PAS/Attend Care (3 person)		\$ -	-				0	\$ -
	Respite/Center		\$ -	-				0	\$ -
	Respite/In-home		\$ -	-				0	\$ -
	PERS (install)		\$ 30.00	-				0	\$ -
	PERS (Month)		\$ 28.00	-				0	\$ -
	Transportation		\$ -	-				0	\$ -
	Transportation wheelchair		\$ -	-				0	\$ -
	RN consultation/Assessment		\$ -	-				0	\$ -
	LPN (in-home) (1 person)		\$ -	-				0	\$ -
	Speech Therapy		\$ -	-				0	\$ -
	OT		\$ -	-				0	\$ -
	PT		\$ -	-				0	\$ -
		12,247		0				12,247	\$ 439,993

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Supports Waiver
EXPENSES

<u>Expense Classification</u>	(a) Expenses per Books	(b) Provider Adjustments <i>(from Schedule I)</i>	(c) Allowable Expenses
A. Direct Care Costs			
1 Salaries - Aides	125,869	-	\$ 125,869
2 Salaries - LPNs		-	\$ -
3 Salaries - RNs		-	\$ -
4 Salaries - Social Services		-	\$ -
5 Salaries - Activities (excl. Act. Dir.)		-	\$ -
6 Salaries Therapist		-	\$ -
a. Physical Therapists		-	\$ -
b. Occupational Therapist		-	\$ -
c. Speech Therapist		-	\$ -
d. Respirational Therapist		-	\$ -
7 Payroll Taxes	9,566	-	\$ 9,566
8 Employee Benefits	11,587	-	\$ 11,587
9 Workers' Compensation		-	\$ -
10 Contract - Aides		-	\$ -
11 Contract - LPNs		-	\$ -
12 Contract - RNs		-	\$ -
13 Contract - Social Services (MSW)		-	\$ -
14 Contract Therapist		-	\$ -
a. Physical Therapists		-	\$ -
b. Occupational Therapist		-	\$ -
c. Speech Therapist		-	\$ -
d. Respirational Therapist		-	\$ -
15 Drugs - OTC & Non-Legend		-	\$ -
16 Medical Supplies		-	\$ -
17 Medical Waste Disposal		-	\$ -
18 Other Supplies		-	\$ -
19 a. Shared Costs (Allocated)* (Specify Source)	<i>Central Office Allocation Tab</i>	15,266	\$ 15,266
19 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
19 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
20 Allocated Costs - Hospital Based		-	\$ -
a. Miscellaneous (specify)		-	\$ -
b. Miscellaneous (specify)		-	\$ -
Total Direct Care Costs	\$ 147,022	\$ 15,266	\$ 162,288

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Supports Waiver

B. Care Related Costs

1 Salaries - Supervisory Staff	24,036	-	\$ 24,036
2 Salaries - Dietary		-	\$ -
3 Payroll Taxes		-	\$ -
4 Employee Benefits		-	\$ -
5 Workers' Compensation		-	\$ -
6 Consultant Fees			
a. Activities Consultant Fees		-	\$ -
b. Nursing Consultant Fees		-	\$ -
c. Pharmacy Consultant Fees		-	\$ -
d. Social Worker Consultant Fees		-	\$ -
7 Food-Raw		-	\$ -
8 Food-Supplements		-	\$ -
9 Supplies	125	-	\$ 125
10 Allocated Costs - Hospital Based		-	\$ -
11 a. Shared Costs (Allocated)* (Specify Source)	<i>Central Office Allocation Tab</i>	42,527	\$ 42,527
11 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
11 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
12 Miscellaneous (specify)		-	\$ -
Total Care Related Costs	\$ 24,161	\$ 42,527	\$ 66,688

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Supports Waiver

C. Administrative and Operating Costs

1 Salaries and Wages - Administrator		-	\$ -
2 Salaries and Wages - Asst Administrator		-	\$ -
3 Salaries and Wages - Medical Director		-	\$ -
4 Salaries and Wages - Housekeeping		-	\$ -
5 Salaries and Wages - Laundry		-	\$ -
6 Salaries and Wages - Maintenance		-	\$ -
7 Salaries and Wages - Drivers		-	\$ -
8 Salaries and Wages - Other Administrative		-	\$ -
9 Salaries and Wages - Owner or Owner/Admin.		-	\$ -
10 Payroll Taxes		-	\$ -
11 Employee Benefits		-	\$ -
12 Workers' Compensation		-	\$ -
13 Contract - Dietary		-	\$ -
14 Contract - Housekeeping		-	\$ -
15 Contract - Laundry		-	\$ -
16 Contract - Maintenance		-	\$ -
17 Consultant Fees - Dietician		-	\$ -
18 Accounting Fees		-	\$ -
19 Amortization Expense Non-Capital		-	\$ -
20 Bank Service Charge		-	\$ -
21 Board of Directors' Fees		-	\$ -
22 Dietary Supplies		-	\$ -
23 Dues		-	\$ -
24 Educational Seminars and Training		-	\$ -
25 Housekeeping Supplies		-	\$ -
26 Insurance - Professional Liability and Other		-	\$ -
27 Interest on Non-Capital and Vehicles		-	\$ -
28 Laundry Supplies		-	\$ -
29 Legal Fees		-	\$ -
30 Linen Supplies		-	\$ -
31 Management Fees and Home Office Costs		-	\$ -
32 Non-Emergency Medical Transportation		-	\$ -
33 Office Supplies and Subscriptions		-	\$ -
34 Postage		-	\$ -
35 Repairs and Maintenance		-	\$ -
36 Taxes and License		-	\$ -
37 Telephone & Communications		-	\$ -
38 Travel		-	\$ -
39 Vehicle Expenses (Gas, Oil, etc..)		-	\$ -
40 Utilities		-	\$ -
41 Allocated Costs - Hospital Based		-	\$ -
42 Maintenance Supplies		-	\$ -
43 Advertising		-	\$ -
44 a. Shared Costs (Allocated)* (Specify Source)	Central Office Allocation Tab	6,518	\$ 6,518
44 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
44 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
45 Miscellaneous (specify)		-	\$ -
Total Administrative and Operating Costs		\$ -	\$ 6,518

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE G - Supports Waiver

D. Property and Equipment

1 Depreciation Expense - (Provide detailed schedules)			
a. Depreciation - Buildings		-	\$ -
b. Depreciation - Furniture & Equipment		-	\$ -
c. Depreciation - Motor Vehicles		-	\$ -
d. Depreciation - Leasehold Improvements		-	\$ -
2 Interest Expense - Capital		-	\$ -
3 Property Insurance		-	\$ -
4 Property Taxes		-	\$ -
5 Rent - Building		-	\$ -
6 Rent - Furniture & Equipment		-	\$ -
7 Auto Lease		-	\$ -
8 Allocated Costs - Hospital		-	\$ -
9 a. Shared Costs (Allocated)* (Specify Source)	Central Office Allocation Tab	1,520	\$ 1,520
9 b. Shared Costs (Allocated)* (Specify Source)		-	\$ -
9 c. Shared Costs (Allocated)* (Specify Source)		-	\$ -
10 Miscellaneous (specify)		-	\$ -

Total Property & Equipment **\$ -** **\$ 1,520** **\$ 1,520**

Sum of Sections A, B, C and D **\$ 171,183** **\$ 59,313** **\$ 230,496**

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE G - STATISTICS SUMMARY

Total Clients all Waivers

303

Waiver Programs	Medicaid	Other State	Private	Total Units	Total Income per Waiver
Community Choice Waiver/EDA	\$ -	\$ -	\$ -	\$ -	\$ -
Long Term Personal Care Sevices	\$ -	\$ -	\$ -	\$ -	\$ -
Children's Choice Waiver	\$ 5,615	\$ -	\$ -	\$ 5,615	\$ 393,091
Supports Waiver	\$ 12,247	\$ -	\$ -	\$ 12,247	\$ 439,993
New Opportunities Waiver	\$ -	\$ -	\$ -	\$ -	\$ -
Residential Options Waiver	\$ -	\$ -	\$ -	\$ -	\$ -
	\$17,862	\$-	\$-	\$17,862	\$ 833,084

EXPENSE SUMMARY

Waiver Programs	Expenses per Books	Provider Adjustments	Allowable Expenses
Community Choice Waiver/EDA	-	-	-
Long Term Personal Care Sevices	-	-	-
Children's Choice Waiver	504,481	94,027	598,508
Supports Waiver	171,183	59,313	230,496
New Opportunities Waiver	-	-	-
Residential Options Waiver	-	-	-
	675,664	153,340	829,004

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE H - CENTRAL OFFICE

EXPENSES

<u>Expense Classification</u>	(a) Expenses per Books	(b) Provider Adjustments <i>(from Schedule I)</i>	(c) Allowable Expenses
A. Direct Care Costs			
1 Salaries - Aides		-	\$ -
2 Salaries - LPNs		-	\$ -
3 Salaries - RNs	56,000	-	\$ 56,000
4 Salaries - Social Services		-	\$ -
5 Salaries - Activities (excl. Act. Dir.)		-	\$ -
6 Salaries Therapist		-	\$ -
a. Physical Therapists		-	\$ -
b. Occupational Therapist		-	\$ -
c. Speech Therapist		-	\$ -
d. Respirational Therapist		-	\$ -
7 Payroll Taxes	4,256	-	\$ 4,256
8 Employee Benefits		-	\$ -
9 Workers' Compensation		-	\$ -
10 Contract - Aides		-	\$ -
11 Contract - LPNs		-	\$ -
12 Contract - RNs		-	\$ -
13 Contract - Social Services (MSW)		-	\$ -
14 Contract Therapist		-	\$ -
a. Physical Therapists		-	\$ -
b. Occupational Therapist		-	\$ -
c. Speech Therapist		-	\$ -
d. Respirational Therapist		-	\$ -
15 Drugs - OTC & Non-Legend		-	\$ -
16 Medical Supplies		-	\$ -
17 Medical Waste Disposal		-	\$ -
18 Other Supplies		-	\$ -
19 Allocated Costs - Hospital Based		-	\$ -
a. Miscellaneous (specify)		-	\$ -
b. Miscellaneous (specify)		-	\$ -
Total Direct Care Costs	\$ 60,256	\$ -	\$ 60,256

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE H - CENTRAL OFFICE

EXPENSES

B. Care Related Costs

1 Salaries - Supervisory Staff	156,000	-	\$ 156,000
2 Salaries - Dietary		-	\$ -
3 Payroll Taxes	11,856	-	\$ 11,856
4 Employee Benefits		-	\$ -
5 Workers' Compensation		-	\$ -
6 Consultant Fees			
a. Activities Consultant Fees		-	\$ -
b. Nursing Consultant Fees		-	\$ -
c. Pharmacy Consultant Fees		-	\$ -
d. Social Worker Consultant Fees		-	\$ -
7 Food-Raw		-	\$ -
8 Food-Supplements		-	\$ -
9 Supplies		-	\$ -
10 Allocated Costs - Hospital Based		-	\$ -
11 Miscellaneous (specify)		-	\$ -
Total Care Related Costs	\$ 167,856	\$ -	\$ 167,856

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE H - CENTRAL OFFICE

EXPENSES

C. Administrative and Operating Costs

1 Salaries and Wages - Administrator	-	\$ -
2 Salaries and Wages - Asst Administrator	-	\$ -
3 Salaries and Wages - Medical Director	-	\$ -
4 Salaries and Wages - Housekeeping	-	\$ -
5 Salaries and Wages - Laundry	-	\$ -
6 Salaries and Wages - Maintenance	-	\$ -
7 Salaries and Wages - Drivers	-	\$ -
8 Salaries and Wages - Other Administrative	-	\$ -
9 Salaries and Wages - Owner or Owner/Admin.	100,000	\$ 100,000
10 Payroll Taxes	-	\$ -
11 Employee Benefits	-	\$ -
12 Workers' Compensation	-	\$ -
13 Contract - Dietary	-	\$ -
14 Contract - Housekeeping	-	\$ -
15 Contract - Laundry	-	\$ -
16 Contract - Maintenance	-	\$ -
17 Consultant Fees - Dietician	-	\$ -
18 Accounting Fees	1,157	\$ 1,157
19 Amortization Expense Non-Capital	-	\$ -
20 Bank Service Charge	-	\$ -
21 Board of Directors' Fees	-	\$ -
22 Dietary Supplies	-	\$ -
23 Dues	-	\$ -
24 Educational Seminars and Training	24,569	\$ 24,569
25 Housekeeping Supplies	-	\$ -
26 Insurance - Professional Liability and Other	-	\$ -
27 Interest on Non-Capital and Vehicles	-	\$ -
28 Laundry Supplies	-	\$ -
29 Legal Fees	-	\$ -
30 Linen Supplies	-	\$ -
31 Management Fees and Home Office Costs	-	\$ -
32 Non-Emergency Medical Transportation	-	\$ -
33 Office Supplies and Subscriptions	-	\$ -
34 Postage	-	\$ -
35 Repairs and Maintenance	-	\$ -
36 Taxes and License	-	\$ -
37 Telephone & Communications	-	\$ -
38 Travel	-	\$ -
39 Vehicle Expenses (Gas, Oil, etc..)	-	\$ -
40 Utilities	-	\$ -
41 Allocated Costs - Hospital Based	-	\$ -
42 Maintenance Supplies	-	\$ -
43 Advertising	-	\$ -
44 Miscellaneous (specify)	-	\$ -
Total Administrative and Operating Costs	\$ 25,726	\$ 125,726

VENDOR NUMBER: 0
 FACILITY NAME: 0
 COST REPORT PERIOD: 1/0/1900 TC 1/0/1900

SCHEDULE H - CENTRAL OFFICE

EXPENSES

D. Property and Equipment

1 Depreciation Expense - (Provide detailed schedules)			
a. Depreciation - Buildings		4,000	\$ 4,000
b. Depreciation - Furniture & Equipment	500	-	\$ 500
c. Depreciation - Motor Vehicles	5,000	-	\$ 5,000
d. Depreciation - Leasehold Improvements	500	-	\$ 500
2 Interest Expense - Capital		3,000	\$ 3,000
3 Property Insurance		-	\$ -
4 Property Taxes		400	\$ 400
5 Rent - Building			
6 Rent - Furniture & Equipment		-	\$ -
7 Auto Lease		-	\$ -
8 Allocated Costs - Hospital		-	\$ -
9 Miscellaneous (specify)		-	\$ -

Total Property & Equipment **\$ 6,000** **\$ 7,400** **\$ 13,400**

Sum of Sections A, B, C and D **\$ 259,838** **\$ 107,400** **\$ 367,238**

VENDOR NUMBER: 0
FACILITY NAME: 0
COST REPORT PERIOD: 1/0/1900 TO 1/0/1900

SCHEDULE K - Certification Statement by Owner, Officer, or Administrator of Facility

I, _____, _____
(Name) (Administrative Title)

of #VALUE!

(Name of Facility)

#VALUE! _____ 0 do certify that I have examined the
(City) (State)

attached report for the cost report period begin 1/0/1900 and ending 1/0/1900 and to the best of my
knowledge and belief, it is a true and correct statement of the information required.

Signature of Authorized Representative of Facility Date

Title

Comments:

Signature of Preparer Date

Name of Preparer