Alaska Department of Health and Social Services
Cost Survey Form Date-February 8, 2017

CERTIFICATION

Provider Business Name: Your Agency's Name
Provider Name: Your Name

Administrative Information:

Address	Your Agency's Address
City, State, Zip	Your Agency's City, State, Zip Code
Phone	Your Agency's Phone #
Email	Your Agency's Email Address
Website	Your Agency's Website
Tax ID (EIN)	Your Agency's Taxpayer EIN
Provider ID	Your Agency's Medicaid Provider ID(s)

Report Period Ending: _____ (month, day, year)
Your cost survey is due within 7 months of your report period ending date.

CERTIFICATION BY CHIEF EXECUTIVE OFFICER

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST SURVEY MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF EXECUTIVE OFFICER

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost survey for the cost survey period ending _____ and that to the best of my knc Waiver Service Direct Care Costs of the provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost survey were provided in compliance with such laws and regulations.

Signature _____

Chief Executive Officer

Date

Alaska Department of Health and Social Services
Form Date-February 8, 2017

EXPENSES

	Your Agency's Name	Your Name
	Period Ending	
	Print Date	8/21/2017

		Expense
Line	**General Service Costs**	Amount
1	Personnel costs - salary/wages	0.00
2	Personnel costs - Fringe benefits	0.00
3	Advertising (Allowable only)	0.00
4	All Other	0.00
5	Building and Maintenance - Salary/wages	0.00
6	Building and Maintenance - fringe benefits	0.00
7	Building and Maintenance - All Other	0.00
	Building/s and Maintenance (single report option)	
8	Staff - Salary/wages	0.00
9	Staff - Fringe benefits	0.00
10	All Other	0.00
	Non-Allowable	
11	Bad Debt/fines/penalties	0.00
12	Lobbying	0.00
13	Fund raising	0.00
14	Donations or contributions	0.00
15	Entertainment	0.00
16	Contingency funds	0.00
17	Grant Costs - all	0.00
18	Marketing/ public relations/advertising - non-allowable	0.00
19	Legal fees/costs - non allowable	0.00
20	All Other	0.00
	Waiver Service Direct Care Costs	
	Adult Day Care (S5100, S5101)	
21	Wages	0.00
22	Fringe Benefits	0.00
23	Program Support	0.00
24	Building/Maintenance	0.00
	Chore (S5120)	
25	Wages	0.00

26	Fringe Benefits	0.00
27	Program Support	0.00
28	Building/Maintenance	0.00
	Day Habilitation (T2021, T2021 HQ)	
29	Wages	0.00
30	Fringe Benefits	0.00
31	Program Support	0.00
32	Building/Maintenance	0.00
	Family Home Habilitation, Adult Foster Care (S5140)	
33	Wages	0.00
34	Fringe Benefits	0.00
35	Program Support	0.00
36	Building/Maintenance	0.00
	Family Home Habilitation, Child Foster Care (S5145)	
37	Wages	0.00
38	Fringe Benefits	0.00
39	Program Support	0.00
40	Building/Maintenance	0.00
	Group Home Habilitation (T2016, T2016 TG)	
41	Wages	0.00
42	Fringe Benefits	0.00
43	Program Support	0.00
44	Building/Maintenance	0.00
	In-home Habilitation (T2017 U4)	
45	Wages	0.00
46	Fringe Benefits	0.00
47	Program Support	0.00
48	Building/Maintenance	0.00
	Intensive Active Treatment (H2011 CG)	
49	Wages	0.00
50	Fringe Benefits	0.00
51	Program Support	0.00
52	Building/Maintenance	0.00
	Meals - Congregate (T2025)	
53	Wages	0.00

54	Fringe Benefits	0.00
55	Program Support	0.00
56	Building/Maintenance	0.00
	Meals - Home Delivered (S5170)	
57	Wages	0.00
58	Fringe Benefits	0.00
59	Program Support	0.00
60	Building/Maintenance	0.00
	Nurse Care/Case Management (T1016 CG)	
61	Wages	0.00
62	Fringe Benefits	0.00
63	Program Support	0.00
64	Building/Maintenance	0.00
	Nurse Care/Case Mgmt. over 200 miles(T1016 TN)	
65	Wages	0.00
66	Fringe Benefits	0.00
67	Program Support	0.00
68	Building/Maintenance	0.00
	Pre-Employment (T2019 CG/TT)	
69	Wages	0.00
70	Fringe Benefits	0.00
71	Program Support	0.00
72	Building/Maintenance	0.00
	Respite (S5150, S5150 U2, S5151, S5151 U12)	
73	Wages	0.00
74	Fringe Benefits	0.00
75	Program Support	0.00
76	Building/Maintenance	0.00
	Supported Employment (T2019, T2019 HQ)	
77	Wages	0.00
78	Fringe Benefits	0.00
79	Program Support	0.00
80	Building/Maintenance	0.00
	Supported Living Habilitation (T2017)	
81	Wages	0.00

82	Fringe Benefits	0.00
83	Program Support	0.00
84	Building/Maintenance	0.00
	Transportation - Trip (T2001 SE, T2003/TN/CG)	
85	Wages	0.00
86	Fringe Benefits	0.00
87	Program Support	0.00
88	Building/Maintenance	0.00
	PCA Direct Care Costs	
	Personal Care Attendant (T1019, T1019 U3)	
89	Wages	0.00
90	Fringe Benefits	0.00
91	Program Support	0.00
92	Building/Maintenance	0.00
	Care Coordination Direct Care Costs	
	Care Coordination (T2022, T1023, T2024 U2)	
93	Wages	0.00
94	Fringe Benefits	0.00
95	Program Support	0.00
96	Building/Maintenance	0.00
	Residential Supported Living Direct Care Costs	
	Adult Res. 5 or fewer beds (T2031 UR, with T2031 TG)	
97	Wages	0.00
98	Fringe Benefits	0.00
99	Program Support	0.00
100	Building/Maintenance	0.00
	Adult Res. 6 to 16 beds (T2031 US, with T2031 TG)	
101	Wages	0.00
102	Fringe Benefits	0.00
103	Program Support	0.00
104	Building/Maintenance	0.00
	Adult Res. 17 beds and greater(T2031, with T2031 TG)	
105	Wages	0.00
106	Fringe Benefits	0.00
107	Program Support	0.00
108	Building/Maintenance	0.00

	Other	
	Other - Healthcare (non-PCA/Waiver)	
109	Wages	0.00
110	Fringe Benefits	0.00
111	Program Support	0.00
112	Building/Maintenance	0.00
	Other - Non- Healthcare	
113	Wages	0.00
114	Fringe Benefits	0.00
115	Program Support	0.00
116	Building/Maintenance	0.00
	Total Expenses - Tie to AFS and WTB	0.00

Alaska Department of Health and Social Services

Form Date-February 8, 2017

Revenue and Statistics Worksheet

Your Agency's Name | Your Name

Period Ending: | Print Date 8/21/2017

PART I	REVENUE			UNITS OF SERVICE		
	Waiver Medicaid	All other Revenue	Total	Waiver Medicaid	All Other	Total
	Paid By HCBS Procedure Code Listed	Service similar to Procedure Code listed. Non Waiver Medicaid, Private/Self Pay, General Relief, VA, or Other.	Waiver + Other Medicaid + Non-Medicaid		Non Waiver Medicaid, Private/Self Pay, General Relief, VA, or Other	Waiver + Other Medicaid + Non-Medicaid
Home and Community Based Waiver Services						
Adult Day Care (15 minute - S5100)	-	-	-	-	-	-
Adult Day Care (Half day - S5101)	-	-	-	-	-	-
Chore (15 minute - S5120)	-	-	-	-	-	-
Day Habilitation - Individual (15 minute - T2021)	-	-	-	-	-	-
Day Habilitation - Group (15 minute - T2021 HQ)	-	-	-	-	-	-
Family Home Habilitation - Adult (Per Day - S5140)	-	-	-	-	-	-
Family Home Habilitation - Child (Per Day - S5145)	-	-	-	-	-	-
Group Home Acuity Add-on (Per Diem - T2016 TG)	-	-	-	-	-	-
Group Home - Room & Board	N/A	-	-	N/A	-	-
Group Home Habilitation (Per Diem - T2016)	-	-	-	-	-	-
In Home Habilitation (15 minute - T2017 U4)	-	-	-	-	-	-
Intensive Active Treatment (H2011 CG)	-	-	-	-	-	-
Meals - Congregate (Per Meal - T2025)	-	-	-	-	-	-
Meals - Home Delivered (Per Meal - S5170)	-	-	-	-	-	-
Nursing care/case management (T1016 CG)	-	-	-	-	-	-
Nursing care/case mgmt. - over 200 miles (T1016 TN)	-	-	-	-	-	-
Pre-employment - Individual (T2019 CG)	-	-	-	-	-	-
Pre-employment - Group (T2019 TT)	-	-	-	-	-	-
Respite (15 minute - S5150)	-	-	-	-	-	-
Respite (Per Day - S5151)	-	-	-	-	-	-
Respite - Family (15 minute - S5150 U2)	-	-	-	-	-	-
Respite - Family (Per Day - S5151 U2)	-	-	-	-	-	-
Supported Employment - Individual (15 minute - T2019)	-	-	-	-	-	-

Supported Employment - Group (15 minute - T2019 HQ)		-	-	-	-	-
Supported Living Habilitation (15 minute - T2017)	-	-	-	-	-	-
Trans. Attendant/Escort (Per Trip - T2001 SE)	-	-	-	-	-	-
Transportation Recipient - Paratransit (Per Trip - T2003 CG)	-	-	-	-	-	-
Transportation Recipient up to 20 miles (Per Trip - T2003)	-	-	-	-	-	-
Transportation Recipient - >20 miles (Per Trip - T2003 TN)	-	-	-	-	-	-
Personal Care Attendant:						
Agency Based (15 minute - T1019)	-	-	-	-	-	-
Consumer Directed (15 minute - T1019 U3)	-	-	-	-	-	-
Care Coordination:						
Case Management - Monthly (T2022)	-	-	-	-	-	-
Plan Of Care Dev. - One Annual (T2024 U2)	-	-	-	-	-	-
Screening - One Initial (T1023)	-	-	-	-	-	-
Residential Supported Living:						
Residential Support 5 beds or less (T2031 UR)	-	-	-	-	-	-
Residential Support 6 to 16 beds (T2031 US)	-	-	-	-	-	-
Residential Support 17 or more beds (T2031)	-	-	-	-	-	-
Residential Support Acuity Add-on (T2031 TG)	-	-	-	-	-	-
Room and Board - Medicaid Clients	N/A	-	-	N/A	-	-
Room and Board - Non-Medicaid Clients	N/A	-	-	N/A	-	-
Other Revenue:						
Rental - all other	N/A	-	-			
Grant revenue (Not including amounts reported above)	N/A	-	-			
All Other	N/A	-	-			
TOTAL (Tie to AFS and WTB)	-	-	-	-	-	-

PART II

Group Staffing Ratios	Group Members	
Day Habilitation - Group (15 minute - T2021 HQ)		:1
Pre-employment - Group (T2019 TT)		:1
Supported Employment - Group (15 minute - T2019 HQ)		:1

Alaska Department of Health and Social Services
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Revenue and Statistics Worksheet

PART III

Position	Number of Paid Hours	Compensation
Administrator	0	0
Assistant Administrator	0	0
Nurse/LPN	0	0
Other non-patient care	0	0
Other Officer	0	0
Other patient care staff	0	0

Note: Number of Paid hours - report the actual hours worked during period.

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RELATED PARTY WORKSHEET

Your Agency's Name **Your Name**
Period Ending

STATEMENT OF EXPENSES FROM TRANSACTIONS WITH RELATED ORGANIZATIONS

This information will be used by the Department of Health and Social Services in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to the facility by common ownership or control, and represent reasonable costs as required under Alaska regulations. If the facility does not complete all of the requested information , the cost survey will be considered incomplete.

Symbols: Use the following symbols to indicate the interrelationship of the facility to related organizations:

A. Individual has financial interest (Owner, stockholder, partner, etc.) in either the related organization or the facility;
B. Financial interest exists between facility and corporation or other organization.
C. Director, officer, administrator or key person of facility or relative of such person has financial interest in related organization;
D. Director, officer, administrator or key person of related organization or relative of such person has financial interest in facility;
E. Individual is director, officer, administrator or key person of facility and related organization;
F. Other - explain

Are there expenses greater than $5,000 which are related to transactions with related organizations/parties?

If you marked 'Yes', continue and complete remainder of this worksheet Yes
If you marked 'No', you do not need to complete remainder of workshee No

Expense Report Line Number	Expense Amount	Name of related party (person or organization)	Percent Ownership	Hours worked	Symbol

Alaska Department of Health and Social Services
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BUILDINGS WORKSHEET

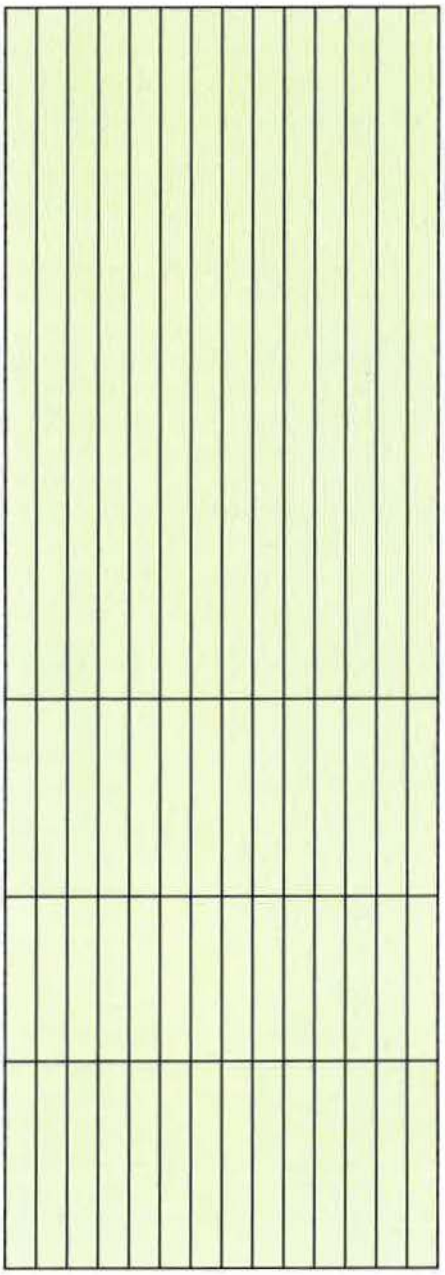
Your Agency's Name **Your Name**

Period Ending:

Building Use Codes

A = General (Administration)
B = Waiver Service area
C = Non-Waiver or other operations

Physical Address	Medicaid Provider Number	Number of Certified Beds (If Applicable)	Building Use Code/s



Alaska Department of Health and Social Services
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Please submit a Department approved home office cost report or fill in the Home Office Worksheet below.

Part I: Expenses

Line	Costs	Amount
1	Buildings and Maintenance	$ -
2	Insurance Premiums	$ -
3	Taxes & Licenses	$ -
4	Salaries of Officers	$ -
5	Bonuses	$ -
6	Salaries & Wages of Others	$ -
7	Payroll Taxes	$ -
8	Employee Benefits	$ -
9	Worker's Compensation	$ -
10	Profit Sharing/ Pension Plans	$ -
11	Legal Fees	$ -
12	Auditing & Accounting Fees	$ -
13	Utilities	$ -
14	Comunications	$ -
15	Travel & Entertainment	$ -
16	Tranportation	$ -
17	Cleaning Office & Admin Supply	$ -
18	Minor Equipment Expensed	$ -
19	Repairs & Maintenance	$ -
20	Dues & Subscriptions	$ -
21	Contributions	$ -
22	Meetings & Conference	$ -
23	Purchased Services	$ -
24	Postage	$ -
25	Information Services	$ -

26	Human Resources	$ -
27	Other Administrative Expense	$ -
28	Other Direct Expense	$ -
	Total Expenses	$ -

Part II: List of Facilities Served

Health Care Facilities	State

Part III: Allocation of Home Office Costs

Home Office Expenses for Alaska	
Total Home Office Expenses	$ -
Percent of Home Office Expenses Allocated to Alaska	#DIV/0!

Part IV: Description of Allocation of Home Office Costs