

**Iowa Department of Human Services
 HCBS SUPPLEMENTAL SCHEDULE D-4
 TO FORM SS-1703-0**

SITE DAILY RATE WORKSHEET
 Effective Date: _____

Provider Name: _____
 NPI _____

New Site
 Existing Site Site Name: _____

If Existing Site Change, provide explanation of changes.

List all Members living at the site including Name, Member ID, Case Manager, Service Procedure Code and indicate if the member is funded by MFP

Member Name	Member ID	Case Manager	MFP (Y/N)	Service Code

Consolidated Site Expenses, Units, and Unit Cost for all Members included in Daily Rate

Form 1703-0 Line:

2120 - Professional Direct Staff	_____
2130 - Other Direct Staff	_____
2200 - Direct Staff Benefits	_____
2300 - Direct Staff Payroll Taxes	_____
3210 - Mileage and Auto Rental	_____
3250 - Agency Vehicle Expenses	_____
3290 - Other Related Transportation	_____
3520 - Other (Consultation Expenses)	_____
4320 - Other Equipment Repair and Purchase	_____
Total Direct Expense	\$ _____
Indirect Expense (limited to 20% of direct expense)	_____
Total Cost	\$ _____
Number of Units Provided	_____
Unit Cost	\$ _____

I certify that I have examined the accompanying schedules of expenses and the calculation of cost of service prepared for this agency and that to the best of my knowledge and belief they are true and correct. I also certify that these schedules were prepared in accordance with instructions contained in this report and the allowable cost of care excludes expenses that were not necessary to provide this care.

SIGNED (Officer or Administrator of Agency)	Date

Contact Provider Cost Audit and Rate Setting at 866-863-8610, 515-256-4610 or email costaudit@dhs.state.ia.us with questions. All completed worksheets should be sent to the Iowa Medicaid Enterprise at the following e-mail address: costaudit@dhs.state.ia.us, fax 515-725-1353 or mail to: Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, P.O. Box 36450, Des Moines, IA 50315.