

# Schedule 1

**SCHEDULE 1 - METHODOLOGY**  
NON-HOSPITAL PROVIDER FOR  
CONTRACTED COUNTY SERVICES

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH  
**FINAL Y/E COST REPORT FOR: FY 10/11**

SUBMISSION DATE: \_\_\_\_\_

REPORTING UNIT/PROVIDER NAME \_\_\_\_\_

FISCAL RU NUMBER/PROVIDER NUMBER: \_\_\_\_\_

LEGAL ENTITY NUMBER: \_\_\_\_\_

## DESCRIPTION/EXPLANATION OF METHODOLOGY

A) Provide an explanation of the methodology used to separate Riverside County contract costs/revenues from non-Riverside County contract costs/revenues. Provide sufficient detail, including additional pages and/or worksheets, if needed, to fully describe how the segregation(s) are determined.  
If your agency has multiple contracts with the Riverside County Department of Mental Health, provide a separate Schedule 1 to explain the methodology used with each contract.

B) Provide an explanation of the methodology used to distribute costs/revenues to the Mode/Sfc within the contract. Attached additional pages and/or worksheets, as needed, to fully describe the methodology.





# Schedule 4

**SCHEDULE 4 - UNITS**  
 NON-HOSPITAL PROVIDER FOR  
 CONTRACTED COUNTY SERVICES

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH  
**FINAL Y/E COST REPORT FOR: FY 10/11**

SUBMISSION DATE: 01/00/1900

REPORTING UNIT/PROVIDER NAME: 0

FISCAL RU NUMBER/PROVIDER NUMBER: 0

MODES	Description	Service Func. Code	Units of Measure
24 hr. Svcs. - 05	Hosp. Inpatient	10-18	Days
	PHF	20-29	Days
	SNF/IMD	30-39	Days
	Adult Crisis Res.	40-49	Days
	Adult Residential	65-69	Days
Day Svcs. - 10	Crisis Stabilization	20-29	Hours
	Day Tx full day	85-89	Hours
O/P Svcs. - 15	Case Management	01-09	Minutes
	M/H Svcs.	10-59	Minutes
	M/H Svcs-TBS	58	Minutes
	Medication Spt.	60-69	Minutes
	Crisis Intervention	70-79	Minutes
Outreach - 45	MH Promotion	10-19	Hours
	Comm Client Svcs	20-29	Hours

				(A)	(B)	(C)
				PROVIDER TOTAL UNITS	LESS: NON-CONTRACT UNITS/ADJ	TOTAL CONTRACT UNITS (including Medi-Cal)
7	<b>UNIT TYPES</b>					
7a	24 hr svcs 05	PHF/SNF/IMD	20-39			-
7b	24 hr svcs 05	Adult Res	65-69			-
7c	Day svcs 10	Crisis Stabilization	20-29			-
7d	Day svcs 10	Day Tx full day	85-89			-
7e	O/P Svcs 15	Case Management	01-09			-
7f	O/P Svcs 15	M/H Svcs	10-59			-
7g	O/P Svcs 15	M/H Svcs-TBS	58			-
7h	O/P Svcs 15	Medication Spt.	60-69			-
7i	O/P Svcs 15	Crisis Intervention	70-79			-
7j	Outreach 45	MH Promotion	10-19			-
7k	Outreach 45	Comm Client Svcs	20-29			-
<b>TOTAL UNITS</b>				<b>0</b>	<b>0</b>	<b>0</b>

# SCHEDULE 5 - SUMMARY AND REIMBURSEMENT

SCHEDULE 5 - SUMMARY REPORT OF  
EXPENDITURES/REVENUES BY MODE/SFC  
NON-HOSPITAL PROVIDER FOR  
CONTRACTED COUNTY SERVICES

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH  
FINAL Y/E COST REPORT FOR: FY 10/11

SUBMISSION DATE: 01/00/1900

Click One ----- **TYPE OF CONTRACT:** **TYPE OF ORGANIZATION** ----- Click One

REPORTING UNIT/PROVIDER NAME: 0

FISCAL RU NUMBER/PROVIDER NUMBER: 0

- Actual Cost without Medi-Cal Units
- Actual Cost with Medi-Cal Units
- 100% Medi-Cal
- IMD
- Negotiated Net Amount
- Negotiated Rate
- PEI Actual Cost
- Non-Profit
- Profit
- ACCOUNTING METHOD** ----- Click One
- Cash
- Modified Accrual
- Accrual

1	MODE OF SERVICE CODE	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(16)	(17)	TOTAL	Check Figure Mode: ALL Svc Fun: ALL
		05	05	10	10	15	15	15	15	45	45	60	60	60	60	72	Non-Outreach		
2	SERVICE FUNCTION CODE	20-39	65-69	20-29	85-89	01-09	10-59	58	60-69	70-79	10-19	20-29	70	71	72				

EXPENSES																				
3	Salaries & Benefits	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
4	Operating Expenses	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
5	Other	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
6x	<b>GROSS COST</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

7	Total Units of Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	\$0.00
8	Cost per Unit of Service	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
8a	Published Charge per Unit	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
8b	SB 900 Rate	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

REVENUES																				
10	Grants Income	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
11	Donation Income	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
12	Program Fees	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
13	Food Stamps	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
14	Rental Income	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
15	Other Income	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
16x	<b>TOTAL REVENUES</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00

17	<b>NET COST</b>	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
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18	Maximum Contract Amount	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
19	Unallowable Medi-Cal Cost (From Schedule 7)	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>ACTUAL COST CONTRACTS ONLY:</b>																				
20a	Calculation: Lower of (Line 17 less Line 19) or Line 18	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
21	LESS: Payment received from County																			\$0.00
	Adjustment (For County use only)																			\$0.00
22a	Balance Due to County (if 21>Reimbursement)																			\$0.00
22b	Balance Due to Provider (if 21<Reimbursement)																			\$0.00

I certify under penalty of perjury that the information contained on these documents is true and accurate.

Director's Signature	Date	Director's Telephone No.	Name of Person to Contact Regarding CR (Print)	Contact Person's Telephone No.	Contact Person's Mailing Address
Director's Name (Print) and Title	Director's Email Address	Contact Person's Email Address	Contact Person's Fax No.	Remittance To - Mailing Address	

# Schedule 6 - Nominal Fee Provider

**SCHEDULE 6 - NOMINAL FEE PROVIDER DETERMINATION**  
 NON-HOSPITAL PROVIDER FOR  
 CONTRACTED COUNTY SERVICES

RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH  
**FINAL Y/E COST REPORT FOR: FY 10/11**

SUBMISSION DATE: 01/00/1900

REPORTING UNIT/PROVIDER NAME: 0

FISCAL RU NUMBER/PROVIDER NUMBER 0

<b>Nominal Fee Provider Determination</b>			
<b>Please answer the following questions:</b>			
<b>Yes</b>	<b>No</b>		
		1.	Does your legal entity have a published schedule of its full (non-discounted) charges?
		2.	Are your legal entity's revenues for patient care based on application of published charge schedule?
		3.	Does your legal entity maintain written policies for its process of making patient indigence determinations?
		4.	Does your legal entity maintain sufficient documentation to support the amount of "indigence allowances" written off in accordance with the above procedures?

COMPLETED BY: \_\_\_\_\_

TITLE OR POSITION: \_\_\_\_\_