

# Schedule 1

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

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

SUBMISSION DATE:

PROVIDER NAME:

FISCAL DEPT ID NUMBER:

CADDS:

## 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 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  
SUBSTANCE ABUSE PROGRAMS  
FINAL Y/E COST REPORT FOR: FY 10/11

SUBMISSION DATE: 01/00/1900

Click One ----->

**TYPE OF CONTRACT:**

- Actual Cost without Medi-Cal Units/Residential
- Actual Cost with Medi-Cal Units
- 100% Medi-Cal

**TYPE OF ORGANIZATION** <----- Check One

- Non-Profit
- Profit

**ACCOUNTING METHOD** <----- Check One

- Cash
- Modified Accrual
- Accrual

PROVIDER NAME: 0

FISCAL DEPT ID NUMBER: 0

1	MODE OF SERVICE CODE SERVICE FUNCTION CODE	PREVENTION		NON-RESIDENTIAL					RESIDENTIAL			ANCILLARY	TOTAL	Check Figure Mode: ALL Svc Fun. ALL		
		Primary	Secondary	Outpatient Treatment			Day Care Habilitative	Detox	Recovery Long-Term	Recovery Perinatal	Case Mgmt. Drug Testing					
2				ODF Individual	Individual Educ.	ODF Group	Group Educ.	Aftercare								
<b>EXPENSES</b>																
3x	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
4x	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
5x	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
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
7	Total Units of Service	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
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
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
8b	Rate Cap	\$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>REVENUES</b>																
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
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
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
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
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
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
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
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
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
19	Unallowable Medi-Cal Cost (From Schedule 6)	\$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
20	<b>ACTUAL COST CONTRACTS ONLY:</b> 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
21	LESS: Payment received from County															\$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 Mailing Address \_\_\_\_\_

Director's Name (Print) and Title \_\_\_\_\_ Director's Email Address \_\_\_\_\_ Contact Person's Email Address \_\_\_\_\_ Contact Person's Fax No. \_\_\_\_\_

Contact Person's Telephone No. \_\_\_\_\_ Remittance To - Mailing Address \_\_\_\_\_