COMMUNITY TREATMENT FACILITY BUDGET SHEET

FISCAL YEAR:

County:

SUBMISSION DATE:

PROVIDER NAME:													
PROVIDER NUMBER:													
COST CATEGORIES	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	**TOTAL**
SALARIES & EMPLOYEE BENEFITS													
OPERATING EXPENSE													
EQUIPMENT													
REMODELING													
GROSS COST													
REVENUES													
a. GRANTS													
b. CLIENT FEES													
c. CLIENT INSURANCE													
d. MEDI-CAL/FEDERAL													
e. MEDI-CAL/NON-FEDERAL													
f. MEDICARE													
g. EPSDT not covered by d or e													
h. AB 3632/SB 90													
i. FOSTER CARE REIMBURSEMENT													
j. OTHER Agency Contribution													
TOTAL REVENUES													
NET COST													
ESTIMATED CHILD DAYS PER MONTH													
NET COST PER CHILD DAY (DIVIDE NET COST BY CHILD DAYS)													

NOTE: Monthly budget estimates are not required, however actual child days per month must be completed for each month.