INTRODUCTION

Cost Survey Period: Please complete the survey using your actual costs for the most recently finished fiscal year (SFY 2020-21).

Cost Survey Purpose: The aim of this survey is to determine the hourly cost specific to the provision of day treatment intensive and day rehabilitation services in the Medi-Cal Specialty Mental Health Services (SMHS) delivery system.

Please complete a separate survey for each provider site and day service that a provider provides. Do not include the cost of outpatient services provided in the same site.

Cost Principles: Please exclude any costs that are not allowable under Medicare cost principles, such as meal services. Refer to the Provider Reimbursement Manual Part 1 published by the Center for Medicare & Medicaid Services for more guidance (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929).

SECTION 1 – PROVIDER INFORMATION

Column A – County: Please select from the drop-down list the county for which this survey is being completed.

Column B – Provider Name: Please enter the provider’s name.

Column C – Provider Number: Please enter the Provider Number that DHCS assigned to the provider when it enrolled in the Medi-Cal Specialty Mental Health program.

Column D – Day Service: Please select from the drop-down list the day service provided at this facility.

SECTION 2 – CLIENT HOURS

Column E – Total Client Hours (7/1/20 – 6/30/21): Please enter the total hours during which clients received treatment in the facility from July 1, 2020, through and including June 30, 2021. Please include all patients regardless of the source of payment.

Example: A day treatment intensive program with eight clients for a three hour program on a single day would count 24 hours towards the total client hours.
SECTION 3 – STAFFING

Please report the annual compensation of treatment staff in Column F and the annual compensation of non-treatment staff in Column G. Please use your best judgement when identifying staff who provide treatment and staff who do not provide treatment. Please report 100% of the annual compensation of each staff member in either Column F or Column G. Do not allocate the annual compensation of a staff member between Column F and Column G.

**Column F – Annual Compensation Treatment Staff:** Please enter in Column F the total salary, wage, and benefit costs incurred for all treatment staff the provider site employed or contracted with to provide services from July 1, 2020, through and including June 30, 2021. Please also include any bonuses or other incentives paid to treatment staff from July 1, 2020, through and including June 30, 2021.

Example: Report in Column F, the annual compensation of a Licensed Clinical Social Worker who provides therapy to beneficiaries participating in a day treatment intensive program.

**Column G – Annual Compensation Non-Treatment Staff:** Please enter in Column G the total salary, wage, and benefit costs incurred to employ all non-treatment staff working in the facility. Non-treatment staff includes leadership and support staff at the facility who do not generally provide treatment to clients. Please also include any bonuses or other incentives paid to non-treatment staff from July 1, 2020, through and including June 30, 2021.

**Column H – Total Annual Compensation:** No entry. Column H is equal to the sum of Column F and Column G.

SECTION 4 – OVERHEAD/OPERATING COSTS

**Column I – Internal Operating Costs:** Please enter in Column I total costs incurred to operate the facility in Fiscal Year 2020-21. Internal operating costs include all non-compensation costs incurred to operate the facility, such as rent, utilities, and supplies. Please exclude any costs that are not allowable under Medicare cost principles, such as meal services, as referenced in the Provider Reimbursement Manual Part 1.

**Column J – External Overhead Costs:** Please enter in Column J total costs allocated to the facility from an external agency, if applicable. For example, if the provider is part of a larger legal entity, the legal entity may allocate a portion of the costs incurred to operate a corporate office, such as rent, utilities, and supplies of the corporate office.

**Column K – Total Operating Costs:** No entry. Column K is equal to the sum of Column I and Column J.

SECTION 5 – TOTAL COSTS

**Column L – Total Costs:** No entry. Column L is equal to the sum of Column H and Column K.
SECTION 6 – COMMENTS

Column M – Comments: Please enter any comments you have pertaining to the survey questions in Column M.

If you have any questions, please email paymentreform@calmhsa.org.