

COMMUNITY TREATMENT FACILITY BUDGET SHEET

FISCAL YEAR \_\_\_\_\_

County: \_\_\_\_\_

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

PROVIDER NAME:													TOTAL
PROVIDER NUMBER:													
COST CATEGORIES	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	
SALARIES & EMPLOYEE BENEFITS													
OPERATING EXPENSE													
EQUIPMENT													
REMODELING													
<b>GROSS COST</b>													
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													
<b>TOTAL REVENUES</b>													
<b>NET COST</b>													
ESTIMATED CHILD DAYS PER MONTH													
<b>NET COST PER CHILD DAY (DIVIDE NET COST BY CHILD DAYS)</b>													

NOTE: Monthly budget estimates are not required, except that estimated child days per month must be completed for each month.