

**Welcome to**

**SAPC**

**Cost Report Orientation**

**For**

**Fiscal Year 2014-15**



# SUBSTANCE ABUSE PREVENTION AND CONTROL

[www.publichealth.lacounty.gov/sapc](http://www.publichealth.lacounty.gov/sapc)

## NON-DMC

NON-DRUG MEDICAL FUNDED CONTRACTS  
COST REPORT ORIENTATION  
FISCAL YEAR 2014-15

1000 South Fremont Avenue  
Building A-9 East, 3rd Floor, North Wing – Unit 34  
Alhambra, CA. 91803

# Topics of Discussion

1. OBJECTIVES
2. IMPORTANT ISSUES
3. SUBMISSION GUIDELINE
4. SOURCE DOCUMENTS
5. TYPE OF CONTRACTS
6. TYPE OF FORMS
7. INSTRUCTIONS FOR REPORTING THE UNITS OF SERVICES
  - ODF (OUTPATIENT DRUG FREE) FORM
  - NON ODF FORM– IOT AND RESIDENTIAL
  - CAL-WORKS ODF AND NON-ODF
8. COMMON ERRORS
9. DEADLINE

# Objectives

- A. To help you complete your cost report timely and accurately.
- B. To update you with changes for FY 2014-15
- C. To answer your questions and concerns.

# What is new for FY 14-15

- The drop down list located in the Program/Sow section of the Summary page was updated to reflect the most current information about the various Sows
- Schedule P2 (Facility Rent/Lease/Depreciation) has a new look, it was reduced to just one page.
- Participant/Client Fees, Public Assistance (Food Stamps), and Third Party Revenue (such as Insurance paid) collected will be offset against allowable cost.



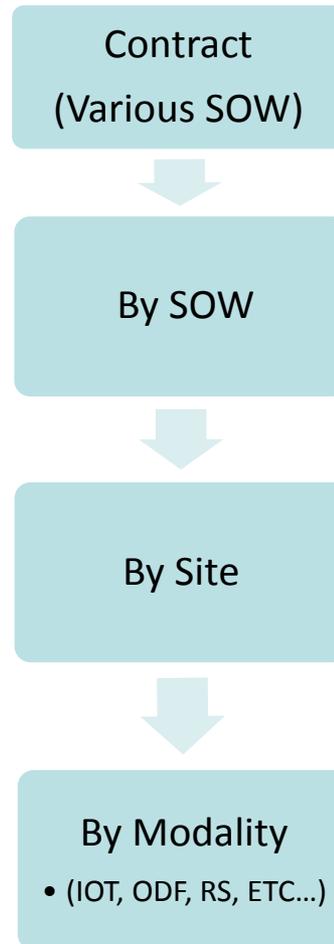
# IMPORTANT ISSUES

## SUBMITTING YOUR COST REPORT:

- Providers must provide unit of service or counseling hours on all cost reports, this includes non-provisional rate contract. Such unit of service refer to main services only, such as Residential (X 9999, Bed Days), IOT (H0015, Visit day), ODF (H0001 Assessment), CASC (H0001 Assessment), ADFLC (S9976, Lodging)
- For ODF-Group, providers need to indicate total number of group sessions provided during the year.
- Make sure the unit of services submitted correspond with the monthly billings. Supplemental units should be reflected in the cost report and billing system. If there is any discrepancy, please contact us immediately. Failure to do so will impact your cost settlement.
- For Non-Provisional Rate (NPR) contracts, please attach the latest county approved budget summary page to cost report.
- Mail or hand delivered a sign cost report certification and care certification forms along with the original cost report for all active contracts.

# Submission Guideline

**Note:** Providers must submit their cost reports by SOW, by Site and by Modality



# Source Documents

## ➤ DOCUMENTS NEEDED FOR COMPLETING COST REPORT

1. THE LATEST COUNTY APPROVED BUDGET

2. FINANCIAL RECORDS

3. STATEMENT OF WORK (SOW)

4. PERFORMANCE DATA REPORT (PDR)

Note: PDR's are only available to providers with Non-Provisional Rate (NPR) contracts that still send their monthly billings by mail

# Type of Contracts (PR, NPR).

## ➤ 1. Cost Reimbursement - Provisional Rate (PR)

A provisional rate contract is a contract by which a temporary rate is established to permit or facilitate the claiming process during the fiscal year. However, at year-end the contract is settled at provider's actual cost less any reported revenues, such as participant/client fees, third party revenue (insurance paid) etc., up to the contract maximum obligation. This amount is then compared to the total amount paid to provider during the fiscal year to determine amount due agency or County

# Type of Contracts (PR, NPR) – Cont.

## 2. **Cost Reimbursement - Non-Provisional Rate (NPR) Line Item**

Non-provisional rate or an actual cost contract, is simply one that requires settlement of the contract in a manner which limits reimbursement to the provider's actual cost of providing services, less any reported revenues, such as participant/ client fees, third party revenue (insurance paid) etc., up to the contract maximum obligation. This amount is then compared to the total amount paid to provider during the fiscal year to determine amount due agency or County.

- 1) The contract provision allows providers to revise the amount of any existing line item(s) by a maximum of ten percent (10%) of the gross budget without prior written approval, and not more than twenty-five percent (25%) of the gross budget with prior written approval from the Program Director or his authorized designee, provided that any increase in any line item(s) of the budget shall be offset by a corresponding decrease in the other line item(s) of the budget. In any event, any revisions made in the gross budget shall not result in any increase in County's maximum obligation during the term of this agreement.

### 2) **Ten Percent (10%) Gross Budget Adjustment Worksheet.**

The NPR contract MUST provide this worksheet and documented with the latest County Approved Cost Line Item Budget when submitting cost report.

# Approved Budget

CITY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES  
ALCOHOL AND DRUG PROGRAM ADMINISTRATION  
BUDGET SUMMARY FOR CONTRACTED SERVICES  
FISCAL YEAR 2009 -2010

SUMMARY PAGE

SAMPLE

Type of Program :  
(Check One)

- Alcohol
- Drug
- Perinatal
- Parolee
- Drug Medi-Cal

Type of Submission:  
(Check One)

- Original
- Amended

Contract Agency: A.B.C. D.B.A.  
Address: 1234 Los Angeles Ave, Los Angeles, CA 90010 City, Zip Code  
Contract Number: PH0001234 Provider Number: 91234 Contract term: From June 30, 2009 To: July 1, 2010  
Licensed Slots: \_\_\_\_\_ Allocated Slots: \_\_\_\_\_ Program Capacity: \_\_\_\_\_ Mod. CPRP

	(1) Proposed Budget	(2) Prior Year Expenditures	(3) (2)-(1) Variance
<b>Program Expenses:</b>			
1. Salaries & Employee Benefits (Sch. P1)	\$25,304	\$39,376	\$14,072
2. Facility Rent/Lease or Depreciation (Sch. P2)	0	0	0
3. Equipment and/or Other Asset Leases (Sch. P3)	0	0	0
4. Services, Supplies & Equip. Depreciation (Sch. P4)	1,646	5,636	3,890
5. Administrative Overhead (Sch. P5)	4,226	6,716	2,490
6. Total Gross Cost (line 1-5)	\$31,176	\$51,828	\$20,452
<b>Income/Revenue:</b>			
<b>ERROR, EXPENSES MUST EQUAL TOTAL REVENUES</b>			
7. County Allocation	\$31,176	\$31,176	\$0
Medi-Cal <input type="checkbox"/> Non Medi-Cal <input checked="" type="checkbox"/>			
8. Participant/Client Fees			0
9. Excess Fees Carryover from Prior Year			0
10. Private Funding/Public Assistance/Other Provider Revenue			0
11. Total Revenue (line 7-10)	\$31,176	\$31,176	\$0
12. Total Units of Service Provided/Projected:			
12a. Service Staff Hours	1,030	2,058	1,028
12b. Service Days or Bed Days			0
12c. Individual Face-to-Face Visits	0		0
12d. Group Visits (No. of participants in Group)	0		0
12e. Group Sessions	0		
13. Gross Cost Per Unit:			
13a. Service Staff Hours (line 6 divided by line 12a)	\$30.27	\$25.00	(\$5.18)
13b. Service Days or Bed Days (line 6 divided by line 12b)			\$0.00
13c. Individual Face-to-Face Visits (line 6 divided by line 12c)	\$0.00		\$0.00
13d. Group Visits (No. of participants in Group) (line 6 divided by line 12d)	\$0.00		\$0.00
14. Net Cost Per Unit:			
14a. Service Staff Hours (line 7 divided by line 12a)	\$30.27	\$15.16	(\$15.12)
14b. Service or Bed Days (line 7 divided by line 12b)			\$0.00
14c. Individual Face-to-Face Visits (line 7 divided by line 12c)	\$0.00		\$0.00
14d. Group Visits (No. of participants in Group) (line 7 divided by line 12d)	\$0.00		\$0.00
15. Individual Slot Cost			
16. Number of Allocated Slot			

Approved for Agency By: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Name Telephone Number: 323-761-8800

COUNTY USE ONLY

Budget Reviewed and Approved by:  
Contract Services Division: \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_  
Financial Services Division: \_\_\_\_\_ Name \_\_\_\_\_ Date \_\_\_\_\_  
Forwarded to Contracts and Grants: \_\_\_\_\_ Date \_\_\_\_\_

fl.cbldgform.xls



# Performance Data Report

## PDR - Contract

**SUBSTANCE ABUSE PREVENTION & CONTROL - FINANCIAL SERVICES DIVISION  
CONTRACT PERFORMANCE DATA REPORT  
FISCAL YEAR 2014-2015**

Provider Name: **ABC**      Contract Number: **PH-000113A**      Gross Program: \$239,145.00      Program Type: Emergency Room Project  
 DRA Address: **ANYTOWN USA**      Performance #: 67600      Revenue: \$39,145.00      Mode of Service: CCR-CP  
 SUP Dist:      Funding Source:      Net Program Funding Amt: \$200,000.00      Contract Type: COST NPRI  
 SPA:      Provider Number: **191254**      Unit Rate: \$0.00

**SAMPLE**

**I. FINANCIAL PERFORMANCE**

Month of Service	Cases Actual Closed	YTD Gross Amount Claimed	Reported Revenue	YTD Reported Revenue	% Actual Reported	YTD Net Amount Requested	Amount Due to be Paid	YTD Amount Paid	Adjustment	Actual Amount Paid on PW	YTD % Fund Budgeted	YTD % Funds Utilized
JUL	21,618.71	21,618.93	4,932.23	4,932.23	10,000.00	10,000.00	15,665.65	15,665.65		20,000.00	73.33%	73.33%
AUG	21,618.71	43,237.82	4,932.23	9,864.46	10,000.00	21,257.32	15,665.65	31,331.31		36,000.00	16.67%	16.67%
SEP	21,618.71	64,856.72	4,932.23	14,796.69	10,000.00	32,999.94	15,665.65	47,000.96		40,000.00	25.00%	25.00%
OCT	21,618.71	86,475.64	4,932.23	19,728.92	10,000.00	44,666.67	15,665.65	62,666.64		50,000.00	33.33%	33.33%
NOV	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
DEC	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
JAN	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
FEB	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
MAR	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
APR	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
MAY	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%
JUN	0.00	86,475.64			0.00	60,000.00		60,000.00	0.00	0.00	50.00%	33.33%

**II. SERVICE PERFORMANCE**

Month of Service	Units/Hours Reported	Cases Reported	YTD Units/Hours Reported	Budgeted Units/Hours	YTD Budgeted Units/Hours	% Over (Under) Budgeted	YTD % Over (Under) Budgeted
JUL			3.00	3.00	3.00	(100.00%)	(100.00%)
AUG			4.00	4.00	4.00	(100.00%)	(100.00%)
SEP			4.00	4.00	4.00	(100.00%)	(100.00%)
OCT			0.00	0.00	0.00	(100.00%)	(100.00%)
NOV			0.00	0.00	0.00	(100.00%)	(100.00%)
DEC			0.00	0.00	0.00	(100.00%)	(100.00%)
JAN			0.00	0.00	0.00	(100.00%)	(100.00%)
FEB			0.00	0.00	0.00	(100.00%)	(100.00%)
MAR			0.00	0.00	0.00	(100.00%)	(100.00%)
APR			0.00	0.00	0.00	(100.00%)	(100.00%)
MAY			0.00	0.00	0.00	(100.00%)	(100.00%)
JUN			0.00	0.00	0.00	(100.00%)	(100.00%)

11/22/2014 11:33 AM

ID. REMARKS



# Statement of Work (SOW) - Sample

## SUBSTANCE ABUSE PREVENTION AND CONTROL

Exhibit B

### RATES, ALLOCATION PER STATEMENT OF WORK, AND CONTRACT MAXIMUM OBLIGATION Effective October 1, 2012

Legal Entity	Statement of Work Funding Source/Program	HCPCS CODE	Modality/ Reimbursable Services	BASE RATE	Staffing Modified RATE	Population Modified RATE	2012-2013 Funding	2013-2014 Funding	2014-2015 Funding
PROVIDER NAME XXXXXXXXXX	General Program Services - Medication Assisted Treatment						202,458	269,945	0
	General Program Services						560,097	746,796	0
	Department of Children Family Services (DCFS)						257,648	343,531	0
	Community Assessment and Services Center Program (California Work Opportunity and Responsibility to Kids)						426,899	569,198	0
	Community Assessment and Services Center Program (General Relief)						144,462	192,616	0
	Community Assessment and Services Center Program (General Population)						179,971	239,961	0
	Community Assessment and Services Center Program (Penal Code 1210 and 3063.1)						163,538	218,050	0
	Community Assessment and Services Center Program (First 5 LA)						562,500	750,000	0
	Community Assessment and Services Center Program (Department of Children and Family Services - DCFS)						115,209	153,612	0
	Community Assessment and Services Center Program (AB 109)						98,498	98,498	0
	General Relief						57,021	76,028	0
	Women's and Children's Residential Treatment Program						657,642	876,856	0
	Perinatal Programs						115,340	153,786	0
	California Work Opportunity and Responsibility to Kids (CalWORKS)						562,519	750,025	0
	CaWORKs Homeless Families Project						56,250	75,000	0
	First 5 Program						188,237	250,982	140,903
	<b>CONTRACT MAXIMUM OBLIGATION</b>						<b>\$ 4,348,289</b>	<b>\$ 5,764,884</b>	<b>140,903</b>



# NPR – Cost Line Item

SAMPLE P1/2  
(COST/1YR)

SAMPLE P2/2  
(COST/1YR)

ABC INC.

BUDGET A

SATELLITE HOUSING CENTER

ITEM	Period of (07/01/10- 06/30/11)	Period of (07/01/11- 06/30/12)
Salaries .....	\$ 55,428	\$ 55,428
Facility Rent/Lease .....	\$ 34,187	\$ 34,187
Equipment Leases .....	\$ 234	\$ 234
Services and Supplies .....	\$ 35,199	\$ 35,199
Administrative Overhead .....	\$ 0	\$ 0
Gross Budget*	\$ 125,048	\$ 125,048

\* Contractor may revise the amount of any existing line item(s) by a maximum of ten percent (10%) of the gross budget without prior written approval of, and not more than twenty-five percent (25%) of the gross budget with prior written approval of SAPC's Director or his/her authorized designee. Therefore, any increase in any line item(s) of the budget shall be offset by a corresponding decrease in the other line item(s) of the budget. In any event, any revisions made in the gross budget, shall not result in any increase in County's maximum obligation during the term of this Agreement.

County reserves the right to withhold payments to Contractor for reasons set forth in this Agreement, including, but not limited to Paragraph 12, Subparagraph A, subsection (5) and Paragraph 14, Subparagraph H, of the ADDITIONAL PROVISIONS.

SH

ABC INC.

SCHEDULE A

SATELLITE HOUSING CENTER

	Period of (07/01/10- 06/30/11)	Period of (07/01/11- 06/30/12)
1. Maximum Allocation .....	\$ 100,000	\$ 100,000
2. Projected Revenue .....	\$ 25,048	\$ 25,048
3. Gross Program Allocation .....	\$ 125,048	\$ 125,048
(Item 1 plus Item 2)		
4. Maximum Monthly Amount/Allocation .....	\$ 8,333	\$ 8,333
(Item 1 divided by the number of months in the period)		

County reserves the right to withhold payments to Contractor for reasons set forth in this Agreement, including, but not limited to Paragraph 12, Subparagraph A, subsection (5) and Paragraph 14, Subparagraph H, of the ADDITIONAL PROVISIONS.

SH





# NPR-10% Gross Budget Adj. Worksheet

# Type of Forms

1. ODF (Outpatient Drug Free)
  2. Non-ODF (IOT, Residential, Ancillary and Prevention)
  3. MAT (MEDICAL ASSISTED TREATMENT)
  4. Cal-WORKS - ODF
  5. Cal-WORKS - Non-ODF
- For ODF form, the Expenditures must be allocated into:
    - Individual (IND) and Group (GRP)
  - MAT and Cal-WORKS have their own forms. For other programs, please use form 1 or 2 whichever is applicable.

# Instructions for reporting the Unit of Services

Units of service should be reported as follows:

## RESIDENTIAL SERVICES :

1. **Bed Days** – The number of available bed days provided during the year.

## NON-RESIDENTIAL SERVICES :

1. **Visit Days** - The number of days a client received day care rehabilitative services.
2. **Service Staff Hours:** This is the direct service staff hours (Counseling Hours).
  - **Group Counseling** – *90 minutes per session*
  - **Individual Counseling** – *50 minutes per session*
3. **Individual Face to Face Visits:** The number of individuals attending individual counseling sessions.
4. **Group Face-to-Face Visits:** The total number of individuals in the group attending group sessions.
5. **Group Sessions:** The total number of sessions held for providing group counseling during the year.

# ODF Form Instructions

## SUMMARY PAGE

1. HEADING : Enter all applicable Information listed in this section. The provider name and mode of service will be posted to all schedules automatically.
2. TOTAL COSTS (Line 1 to 5): No entry required. All Information are linked from Schedule P1 to P5.
3. REVENUE (Line 7 to 10):  
Line 7, 7.1 and 7.2.: Participant/Client Fees, Public Assistance (Food Stamps),  
and Third Party Revenue (Insurance Paid):  
Enter above collected revenue during the Fiscal Year to each line. **Such amount will be offset from the Allowable Cost.** This excludes County Reimbursement.  
Line 8. Excess Fees Carryover :  
Client fees collected during last Fiscal Year 2013-14 in excess of budgeted projection, but were not spent during the same Fiscal Year and therefore, carried over to this Fiscal Year 2014-15.

# ODF Form Instructions

## SUMMARY PAGE (cont.)

## REVENUE (cont.)

### Line 9. Excess Fees to be Carried Forward to next Fiscal Year 2015-16:

Client fees collected during the Fiscal Year 2014-15 in excess of budgeted projection, but not spent during the same fiscal year, therefore are carried forward to the next Fiscal Year 2015-16.

**Please note, any fees carried forward** are subject to the review of the County Program Advisory Board and the approval of both the County Board of Supervisors and the State Department of Alcohol and Drug Program. This amount should be included in the budget for FY 2015-16 excess fees carryover calculation.

### Line 10. Private Funding/Public Assistance/Other Provider Revenue:

Enter the total amount of each of these funding sources, such as fund raising, donation, interest and others if applicable.

### Line 11. Total Revenue: Formulated no entry required

# ODF Form Instructions

## UNITS OF SERVICE (Line 13a to 13e)

SUMMARY PAGE (cont.)

- **MANDATORY, DO NOT LEAVE BLANK.**
  - Do not include Ancillary hours for main services such as Bed days etc...**
- **DETAILED INSTRUCTIONS ARE ATTACHED TO THE COST REPORT FORM.**
- **MAKE SURE THE UNITS REPORTED ARE ACCURATE AND MATCH YOUR BILLINGS. IF THERE IS ANY VARIANCE, PLEASE CONTACT US IMMEDIATELY.**

**Line 13a. Total Staff Hours:** The available staff hours spent providing services. Please see detailed instructions attached to the cost report forms.

**Line 13b. Total Service Staff Hours (Counseling Hours):** Enter the total direct service staff hours (counseling hours) for Individual and Group.

**Line 13c. Total Individual Face-to-Face Visits:** Total number of **Individual participants**.

**Line 13d. Total Group Visits:** Total number of **participants in Group Sessions**.

**Line 13e. Total Group Sessions:** Total number of **Group Sessions** provided during the year.

# ODF Form Instructions

## SCHEDULE P1 – SALARIES AND EMPLOYEE BENEFITS

**HEADING:** Information is automatically linked from Summary Page.

**Column (A) to (J)**

**(A) TITLE OF POSITION :**

**Employee with taxes and benefits paid** - List each non-consultant position working on the contract by title.

**Employee without taxes and benefits paid** - Report on Schedule P4, page 1 of 2, on the line for **Consultants**.

**(B) MONTHLY SALARY:** For each position listed in (A) indicate the monthly salary based on a 40 hours work-week as if the individual had worked for the company 100% of the time.

**(C) % OF TIME EMPLOYED BY AGENCY :** Indicate the % of time an employee worked for the organization. Full time = 100%, half time = 50%, quarter time = 25% (number of hours per week divided by 40). This percentage should not exceed 100% or 40 hours per week.

# ODF Form Instructions

## SCHEDULE P1 – SALARIES AND EMPLOYEE BENEFITS (continued)

- (D) **% OF TIME SPENT ON CONTRACT SERVICES:** % of time spent on this contract.
- (E) **% OF TIME SPENT ON DIRECT SERVICES:**  
% of time charged to this contract for providing direct services. Direct services are those that deal directly with clients.
- (F) **TOTAL ANNUAL SALARY:** Enter amounts from financial records for this position.
- (G) **ACTUAL EXPENDITURES ODF - IND:**  
Actual cost from payroll or general ledger charged to ODF Individual Services.
- (H) **ACTUAL EXPENDITURES ODF - GRP:**  
Actual cost from payroll or general ledger charged to ODF Group Services.
- (I) **COUNTY APPROVED BUDGET:**  
Indicate the amount from your latest approved budget. Applicable to Non-Provisional Rate Contract (NPR) only.
- (J) **VARIANCE:** Formulated. No entry required.
- (K) **EMPLOYEE BENEFITS:**  
Enter the amounts from your financial records. Itemize employee benefits on the spaces provided in the lower left hand corner. Indicate the percentage of employee benefits to total salaries.

# ODF Form Instructions

NEW

## SCHEDULE P2 – FACILITY RENT/LEASE OR DEPRECIATION

**FACILITY ADDRESS:** Mandatory. Please enter complete facility address.

**( A ) TOTAL ANNUAL RENT/LEASE:**

Enter actual rent/lease from financial records for the contract period

**( B ) TOTAL GROSS SQUARE FOOTAGE:** Enter actual square footage of the facility.

**( C ) COST PER SQUARE FOOTAGE:** Formulated. No entry required.

**( D ) & ( E ) PROGRAM SQUARE FOOTAGE FOR INDIVIDUAL AND GROUP:**

Enter square footage charged to Individual and Group Services

**( F ) & ( G ) ACTUAL EXPENDITURES FOR INDIVIDUAL AND GROUP:**

Formulated. No entry required. This amount should agree with your financial records.

**( H ) TOTAL COST CHARGED TO PROGRAM**

Formulated. No entry required.

**( I ) COUNTY APPROVED BUDGET:**

Indicate the amount from your latest approved budget. Applicable to Non-Provisional Rate Contract (NPR) only

**( J ) VARIANCE:** Formulated. No entry required.

**( K ) EXPLANATION:** Use this box to explain the variance, if any.



# ODF Form Instructions

## SCHEDULE P2 – FACILITY RENT/LEASE OR DEPRECIATION (cont.)

### **II. FACILITY OWNED**

**(A,B,C,D,F,G)** – Fill-out information in appropriate boxes.

**Do not include land cost in facility cost (box B)**

**(E) DEPRECIABLE COST:**

Facility cost (B)+ Facility improvement (C)-Salvage value (D).

**(H) ANNUAL DEPRECIATION EXPENSE CHARGED TO AGENCY:** Formulated.

**(I & J) ACTUAL ANNUAL DEPRECIATION CHARGED TO PROGRAM:**

Enter amount of actual depreciation charged to Individual and Group Services.

**(K) COUNTY APPROVED BUDGET:** Indicate the amount from your latest approved budget . Applicable to Non-Provisional Rate Contract (NPR) only

**(L) VARIANCE:** Formulated. No entry required.

# ODF Form Instructions

## SCHEDULE P3 – EQUIPMENT AND OTHER ASSET LEASES

### **( A ) DESCRIPTION OF LEASES:**

The Los Angeles County, Department of Public Health encourages the leasing of items classified as Fixed Assets Equipment. For this column, itemize those assets classified as fixed assets, equipment or any asset regardless of classification costing over \$5,000 and \$500 (Perinatal and Drug (Medi-Cal) per leased unit and has an expected service life of more than three years. Leased items costing less than the above must be itemized in the "Miscellaneous Services and Supply Items" section of Schedule P4, page 2 of 2

### **( B ) VALUE OF EQUIPMENT:**

Enter the lesser of the purchase price or market value of the leased assets/equipment.

### **( C ) NUMBER OF ITEMS:**

Enter the number of leased items from column (A).

### **( D & E ) ACTUAL EXPENDITURES CHARGED TO ODF IND AND GRP:**

Enter the actual cost for leased equipment and/or other assets charged to this contract for Individual and group services.

### **( F ) COUNTY APPROVED BUDGET:**

Indicate the amount from your latest approved budget. Applicable to Non-Provisional Rate Contract (NPR) only.

# ODF Form Instructions

## SCHEDULE P4 – SERVICE, SUPPLIES & EQUIPMENT DEPRECIATION

### PAGE 1 OF 2

- (A) **ITEM:** Review this column for appropriateness and accuracy in terms of service and supplies used by your agency. If items cannot be found, use page 2 of 2 under “Miscellaneous Services and Supply Items” to report cost. Please note that space is provided for bookkeeping fees which is separate from consultant services.
- (B & C) **ACTUAL EXPENDITURES-ODF INDIVIDUAL AND GROUP:** Allocate the actual cost for Individual and Group services.
- (D) **COUNTY APPROVED BUDGET:** Enter the amount from the latest County Approved Budget. Applicable to Non-Provisional Rate Contract (NPR) only

### PAGE 2 OF 2

- (A) **MISCELLANEOUS SERVICE AND SUPPLY ITEMS:** In this column, itemize expenditures not found under column (A), page 1, including leased equipment not included in Schedule P3 because of the program cost limitations.
- (B & C) **ACTUAL EXPENDITURES-ODF IND & GRP:** Enter the actual cost of miscellaneous services and supply items listed in column (A) for Individual and Group services.
- (D) **COUNTY APPROVED BUDGET:** Indicate the amount from your latest approved budget. Applicable to Non-Provisional Rate Contract (NPR) only

# ODF Form Instructions

## SCHEDULE P4, PAGE 2 of 2 (cont.)

### **(A) DEPRECIATION FOR EQUIPMENT/FIXED ASSETS:**

In accordance with the “Fixed Assets Classification Guidelines developed by the County Auditor-Controller Accounting Division,” the County of Los Angeles, Department of Public Health, Substance Abuse Prevention and Control will not pay for the initial outlay of funds for items classified as fixed assets and equipment. However, agencies may depreciate such fixed assets, and equipment over a period of not less than three years from the date of purchase and charge depreciation expense to the contract for the appropriate amount. Depreciation is limited to cover those periods the contract is in effect and over the periods benefited.

**(B) UNIT COST:** Enter the cost of the items listed in column (A).

**(C) NUMBER OF ITEMS:** Enter the number of items identified in column (A).

**(D&E) ACTUAL EXPENDITURES-ODF INDIVIDUAL AND GROUP SERVICES:**

Enter the actual depreciation cost charged to Individual and Group Services.

**(F) COUNTY APPROVED BUDGET:**

Indicate the amount from your latest approved budget . Applicable to Non-Provisional Rate Contract (NPR) only

# ODF Form Instructions

## SCHEDULE P5 – ADMINISTRATIVE OVERHEAD

Administrative Overhead, as defined in the “State Department of Alcohol & Drug Programs Audit Assistance Guide” are indirect costs that were incurred for a common or joint purpose benefiting more than one cost objective, and not readily assignable to a specific cost objective.

### These Costs involve:

- A. Salaries, wages, and employee benefits of administrative personnel whose effort benefits more than one cost objective.
- B. Operational costs and maintenance costs which benefit more than one cost objective.

# ODF Form Instructions

SCHEDULE P5 (cont.)

## 3 SUGGESTED METHODS TO CALCULATE THE PROGRAM ADMINISTRATIVE OVERHEAD EXPENSE (O.H.)

CHOOSE ONE OF THE FOLLOWING METHODS:

### I. ADMIN. O.H. EXPENSE AS A PERCENTAGE OF TOTAL AGENCY EXPENSES

1. **TOTAL ADMINISTRATIVE EXPENSE POOL:** Enter total administrative expenses of the agency.
2. **TOTAL AGENCY EXPENSES:** Enter the total agency expenses.
3. **ADMINISTRATIVE OVERHEAD RATE:** Formulated. No entry required.
4. **PROGRAM EXPENSES (A1) and (A2):** Formulated. No entry required. Data is automatically linked from the Cost Report Summary Page line 1 through 4.
5. **TOTAL PROGRAM EXPENSES:** Add lines 1 through 4. Formulated.
6. **ACTUAL EXPENDITURES-ODF IND (B):** Formulated. No entry required. Multiply Total Program Expenses ( I ) by the Administrative Overhead Rate. This amount will automatically post to line 5, column (1), on the Summary Page.
7. **ACTUAL EXPENDITURES ODF GRP (C):** Formulated. No entry required. Multiply Total Program Expenses ( G ) by the Administrative Overhead Rate. This amount will automatically post to line 5, column (2), on the Summary Page.
8. **COUNTY APPROVED BUDGET (D):** Indicate the amount from your latest approved budget .  
Applicable to Non-Provisional Rate Contract (NPR) only

# ODF Form Instructions

## SCHEDULE P5 (cont.)

### II. ADMIN. O.H. EXPENSE AS A PERCENTAGE OF TOTAL DIRECT AGENCY SALARIES

1. **TOTAL DIRECT PROGRAM SALARIES:** Post Total Direct Salary from col. (G) plus col. (H) on Schedule P1, page 1. **DO NOT INCLUDE EMPLOYEE BENEFITS.**
2. **TOTAL DIRECT AGENCY SALARIES:** Enter the total direct salaries paid by the agency.
3. **ADMINISTRATIVE OVERHEAD RATE( A ):** Formulated. Total Direct Program Salaries divided by Total Direct Agency Salaries.
4. **ADMINISTRATIVE EXPENSE POOL:** Enter total administrative expenses by Individual and Group Counseling Services for the agency.
5. **ACTUAL EXPENDITURES-ODF IND (B) AND ODF GRP (C):** Formulated. Administrative Expense Pool for ODF Individual and ODF Group multiplied by Administrative Overhead Rate (A) respectively.
6. **COUNTY APPROVED BUDGET (D):** Indicate the amount from your latest approved budget . Applicable to Non-Provisional Rate Contract (NPR) only

# ODF Form Instructions

## SCHEDULE P5 (cont.)

### **III. OTHER METHOD USED TO CALCULATE ADMIN O.H. EXPENSES**

If you use other method, explain the method and attach all worksheets used to calculate Administrative Overhead Expense.

#### **Please note that:**

Actual Admin. O. H. expenditures must be identified separately between Individual and Group Services.

Must Manually Post Total to line 5, column (1) and (2), on the Summary Page.

Also post the amount from the latest County Approved Budget to line 5, columns (3) on the Summary Page.

(Please read detailed instructions attached to Forms).

# Non-ODF - Units of Service Instructions

## SUMMARY PAGE

### UNITS OF SERVICE (Line13)

1. **Staff Hours:** Total staff hours for providing services.  
Do not include Ancillary Hours
2. **Bed Days:** Total number of bed days for services.
3. **Visit Days:** Total number of days the clients received Intensive Outpatient Treatment

# Cal-Works ODF – Units of Services Instruction

## SUMMARY PAGE

### UNITS OF SERVICE (Line 13a to 13e)

**13a. Total Service Hours for Orientation & Outreach and Case Management:**

Total hours for providing O&O and Case Management services.

**13b. Total Service Staff Hours (Counseling Hours):**

Total direct treatment service staff hours.

**13c. Total Individual Face-to-Face Visits:**

Total number of **Individual** participants.

**13d. Total Group Visits:**

Total number of participants in **Group Sessions**.

**13e. Total Group Sessions:**

Total number of **Group Sessions** provided for the year.

# Cal-Works Non-ODF Units of Service Instructions

## SUMMARY PAGE

### UNITS OF SERVICE (Line 13a and 13b)

#### **13a. Total Service Hour:**

The hour worked where **Orientation & Outreach** and **Case Management** activities were provided directly to Cal-WORKS and GAIN recipients.

#### **13b. Total Units of Service (Staff Hours, Resident Day, Intensive Outpatient Treatment Day):**

Indicate the actual units of service provided e.g. Staff Hour, Resident Day, Intensive Outpatient Treatment Day)

- Please note, if there are units that were not disclosed on your monthly claim for reimbursement but should be charged to this contract, include these units in the cost report and submit supplemental claims to Cost Reimbursement Unit.

# Illustration of ODF Cost Report Form



# Common Errors:

## 1. Summary Page

- Missing Service Period
  - Incorrect Contract number.
  - Missing Contract Amount
  - Missing Program/SOW Information
  - Missing SOW Amount
  - Provider Number does not match with facility address
  - Missing signed Cost Report Certification and CARE Certification pages
  - Missing Contact Information
  - Missing County Approved Budget Information when applicable
- ✓ The signature confirms that all information is correct and corresponds to the Agency's financial records. Please make sure that the Certification Page is signed by the authorized person and completely filled out with contact person's name, email address and phone/fax number in case we need to call for questions concerning your cost report.

## 2. Schedule P2 - Facility Rent/Lease or Depreciation

- Missing Facility Address
- ✓ Please fill out the service facility address where the services were provided. If multiple facilities, use additional schedules for each facility.

# Common Errors, cont.

## 3. Revenue

- County reimbursement are being reported under revenue.
- ✓ **Please do not include County Reimbursement as Revenue.**

## 4. Units of Service Information

- Missing units of service information.
  - Units do not match with billings.
  - ✓ Please always provide the unit information. The unit information on the Summary Page can be obtained from the billings.
  - ✓ If there are units that were not disclosed on your monthly claim for reimbursement but should be charged to this contract, include these units in the cost report and submit supplemental claims to CRU.
  - ✓ NPR contract (Cost Line-Item Non-Provisional rate) - actual units of service/staff hours in accordance to the contract modality is required for reporting purposes.
  - ✓ Billings submitted after July 8 will be settled through cost report settlement.
- ❖ **Please note incorrect unit(s) reported on the cost report will impact your cost settlement. Always make sure the reported unit(s) is accurate.**



# Mandatory

## Units of Services

All cost reports, including cost reimbursement line item contracts (NPR) must have the units of service reported before submission.

**PLEASE DO NOT LEAVE THIS INFORMATION BLANK.**

# DEADLINE

**ALL COST REPORTS ARE DUE ON/BEFORE **AUGUST 15, 2015****

## **COST REPORT SUBMISSION CHECK LIST**

- 1. Original cost report. **Do not staple or bind Cost report.**
- 2. Summary page of the most current county approved budget for Non-Provisional Rate contract (NPR)
- 3. Signed care certification
- 4. Signed cost report certification

MAIL TO:

**COUNTY OF LOS ANGELES  
DEPARTMENT OF PUBLIC HEALTH  
SUBSTANCE ABUSE PREVENTION AND CONTROL  
1000 SOUTH FREMONT AVENUE  
BUILDING A-9 EAST, 3rd FLOOR, NORTH WING, UNIT 34  
ALHAMBRA, CA 91803**

# COST REPORTING UNIT

Lisa Lee	(626) 299-4165	<a href="mailto:lilee@ph.lacounty.gov">lilee@ph.lacounty.gov</a>
Alex Domond	(626) 299-4156	<a href="mailto:adomond@ph.lacounty.gov">adomond@ph.lacounty.gov</a>
Terry Yang	(626-299-4158	<a href="mailto:tyang@ph.lacounty.gov">tyang@ph.lacounty.gov</a>
Zenaida Arenas	(626) 299-4584	<a href="mailto:zarenas@ph.lacounty.gov">zarenas@ph.lacounty.gov</a>
Rhona Laurie	(626) 299-4167	<a href="mailto:rarzu@ph.lacounty.gov">rarzu@ph.lacounty.gov</a>