

St. Clair County Community Mental Health
**Contract Agencies Providing Non-Residential/Supported Living Arrangement
 Services Cost Calculation – Single Rate Format**

Provider: _____ Program Name: _____

Provider Address: _____ Fiscal Year: _____

Service Unit Code: _____

Unit Type: _____

Direct Costs

A. Direct Care Personnel Costs

Salaries and Wages _____
 Payroll Taxes _____
 Employee Health and Benefits _____
 Workers' Compensation _____
 Other Personnel Costs (specify below) _____
 Other: _____
 Other: _____
Total Direct Care Personnel Costs: _____

B. Operations

Supplies _____
 Communications _____
 Contractual _____
 Equipment Related:
 Lease Expense _____
 Repairs & Maintenance _____
 Insurance _____
 Vehicle Related:
 Lease Expense _____
 Repairs & Maintenance _____
 Insurance _____
 Other Vehicle Related Costs _____
 Non-Fringe Insurance _____
 Other Operating Costs (specify below) _____
 Other: _____
 Other: _____
Total Operations Costs: _____

Indirect Costs

A. Overhead

Building Related
 Lease Expense _____
 Repairs & Maintenance _____
 Insurance _____
 Other Building Related Costs _____

B. Administration

Salaries _____

Payroll Taxes _____

Workers' Compensation _____

Health & Welfare Benefits _____

Retirement Benefits _____

Other Administrative Costs (specify below) _____

Other: _____

Other: _____

C. Other Allocated Costs

Errors & Omissions Insurance _____

Audits _____

Other Allocated Costs (specify below) _____

Other: _____

Other: _____

D. Depreciation

Depreciation _____

Total Indirect Costs: _____

Total Costs (Direct + Indirect)

Total Costs: _____

Other Revenue

Other Revenue (specify below) _____

Other: _____

Other: _____

Total Other Revenue: _____

Net Cost to CMH: _____

Units of Service to be Provided: _____

Cost per Unit: _____

(Total Costs/Units of Service to be Provided)



The "1" is just a placeholder. Change it to the # of units the agency will provide using the costs above.