BEHAVIORAL HEALTH ACCOUNTING AND AUDITING GUIDELINES FY 2013

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Office of Behavioral Health and Department of Health Care Policy and Financing
Accounting and Auditing Guidelines

Chapter 1: Overview

CHAPTER 1: OVERVIEW

PURPOSE

These guidelines, in conjunction with the AICPA Audit and Accounting Guide, Health Care Organizations, most recent edition and the AICPA Audit and Accounting Guide, Not-For-Profit Organizations, most recent edition, address two principal objectives:

1. To provide guidelines for recording and reporting revenues and expenses of Colorado's behavioral health services delivery system. They are intended to be:

- responsive to the informational needs of Colorado's behavioral health system,
- sensitive to constraints and limitations on accounting for and reporting on revenues and expenses within the behavioral health system, and
- incorporative of generally accepted accounting principles and auditing standards and procedures.

2. To provide a comprehensive cost reporting system for Colorado's behavioral health providers. The cost reporting system is intended to

- define cost classification and basic cost-accounting standards,
- capture cost data for services provided,
- capture utilization for those services with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes,
- captures utilization for Relative Value Unit (RVU) weights for Mental Health Service and Substance Use Disorder (SUD) Services, and
- calculate a base cost per RVU unique to each center or clinic for Mental Health and Substance Use Disorder (SUD) Services.

MENTAL HEALTH BACKGROUND

In 1976, Colorado's mental health service delivery system, consisting of twenty-four centers and clinics received state funding based on a percentage of the unit cost of services rendered. The standard reimbursement percentage was based on the ratio of costs unrecovered through non-state sources to the total cost of services. Each center and clinic provided at least outpatient care and consultation/education services, while others offered expanded services such as inpatient care, partial care and other twenty-four hour care. Accompanying the wide variations in types and amounts of mental health services was widely varying estimates of unit costs for these services.

This disparity in unit costs could have been the result of genuine differences in the resources used in providing the services. But the differences in estimates may have been attributed to variations in cost accumulation and allocation procedures and to variations in accumulating

operating statistics used in determining the unit costs of services. If the wide variations were attributable to accounting and statistical variations, in whole or in part, and not to real differences in resource consumption, allocation of state funds could not be either accurate or equitable.

Because of the variance among the reported unit costs and because of their importance in the allocation of state funds, a decision was made that

. . . the Division of Mental Health, Department of Institutions, (name is now Office of Behavioral Health, Department of Human Services) with the assistance of the Colorado Association of Community Mental Health Centers and Clinics, (name is now The Colorado Behavioral Healthcare Council) undertake an intensive study by management and accounting experts of the cost-finding, cost accounting and unit-cost calculations, approaches, and techniques to be employed by centers and clinics.

. . . that the end product of this intensive study by management and accounting experts be a recommended set of standards, operating procedures and accounting procedures for centers and clinics to be implemented in successive steps starting with the FY 1977-78 budget request.

MENTAL HEALTH DEVELOPMENT OF THE GUIDELINES

The Accounting and Auditing Guidelines (the guidelines) were first developed in 1976 through a cooperative venture of the Colorado Association of Community Mental Health Centers and Clinics (CAMHCC), the Office of Behavioral Health, and consultants from the School of Accountancy at the University of Denver. This 1997 printing incorporates 1980 revisions made in the original guidelines with the assistance of Deloitte, Haskins and Sells, and 1983, 1987, and 1991 revisions made by the Office of Behavioral Health in conjunction with the Colorado Association of Community Mental Health Centers and Clinics. This 1997 version includes new pronouncements from the accounting profession, the State's new Medicaid capitation program, 1996 changes to the Single Audit Act, a new chapter on management of client funds and other relevant updates.

Effective July 1, 2002, the Office of Behavioral Health (OBH) became one of the three units, which comprise the Office of Behavioral Health and Housing (OBHH) within the new Colorado Department of Human Services (CDHS). The Department of Human Services was established as a result of merging the Department of Institutions and the Department of Social Services. The Department of Human Services and the accompanying re-organization within it, encourages coordinated approaches to service planning and financing with an increased focus on effectiveness, efficiency, and accountability. The 1997 revisions to the guidelines were made with the idea that entities, in addition to OBH, within and outside the Department of Human Services (such as Regional Treatment Centers under contract to the Department of Health Care Policy and Finance (HCPF)) will be using the guidelines.

In February, 2009, HCPF hired Public Consulting Group, Inc. (PCG) to help update the

guidelines and to combine the two different versions used by OBH and HCPF into one set of guidelines. Additionally, PCG, redesigned the reporting of costs by the Community Mental Health Centers to allow HCPF to move from a unit pricing methodology to the development of a Relative Value Unit (RVU) pricing schedule, as recommended in the Medicaid Mental Health Performance Audit for November 2006 (Mercer Audit) regarding accounting methodology for encounter pricing.

SUBSTANCE USE DISORDER BACKGROUND

Until 1997 the cost for a unit of service for a Substance Use Disorder was obtained from the provider's independent audits. There was sufficient detail in the audits to cost all funded services and develop modified rates for urban and rural providers. With the advent of the Managed Service Organizations in 1997, the Diagnostic Related Group (DRG) costing was developed and updated until 2004, when the State was no longer able to explicitly and accurately update this information. In 2010 the DRG methodology was eliminated from contracts.

APPLICABILITY

These guidelines are to be observed by providers of behavioral health services under contract, subcontract or general auspices of the Office of Behavioral Health, Colorado Department of Human Services (OBH). Funded providers will file an annual financial statement (AFS), per Exhibit A in the appendix, as well as a Supplementary Cost Report, per Exhibit C in the appendix, with OBH. These guidelines are also applicable to Behavioral Health Organizations (BHO) under contract with the Colorado Department of Health Care Policy and Financing (HCPF) to administer the Medicaid Mental Health Capitation Program. BHOs will file an annual financial statement (AFS), per Exhibit B in the appendix, with HCPF. All contractors assume responsibility for observance of these guidelines consistent with underlying agreements and program objectives.

UPDATING THE GUIDELINES

Effective FY 2010 and forward, a committee will convene on an annual basis to evaluate the guidelines for their applicability to the present circumstances and recommend changes. The committee will consist of representatives from OBH, HCPF, and the funded Behavioral Health providers (including auditors). Any changes needed to the guidelines must be agreed upon and implemented by April 30th for implementation in the new fiscal year. OBH and HCPF as the granting, making, and funding entities will have the final authority in approving updates to the guidelines to ensure compliance with state and federal regulations.

Chapter 2: Cost Accounting Standards

CHAPTER 2: COST-ACCOUNTING STANDARDS

These cost-accounting standards are designed to promote uniformity and consistency in cost-accounting and cost-reporting methods along with adequate cost-accounting records for behavioral health operations.

Standard #1. Costs are to be estimated, accumulated and reported on a consistent basis. Consistency is required in classification of costs as a direct or indirect cost and the method used in allocating indirect costs to direct cost centers.

Reasonable cost information trails are required to permit tracking of costs into the reported actual costs. Comparative reports of historical costs of operations, programs and services also require adherence to the same rules of consistency. Providers will be required to report data uniformly, which helps to measure relative efficiency of providers, ensure services are provided equitably across the state, and evaluate effectiveness of programs. These standards will provide OBH, HCPF, and the funded behavioral health providers essential information for contract management.

Standard #2. Applicable accounting standards require maintenance of accounting records that reflect the classification of expenses by both natural and functional categories. Expenses should be coded at the time of initial recording to accomplish both the natural and functional classification.

Not-for-Profit organizations can use two approaches to provide information about expenses of the organizations (functional and natural). These terms are defined in the, AICPA Audit and Accounting Guide, Not-for-Profit Organizations, most recent edition and AICPA Audit and Accounting Guide, Health Care Organizations, most recent edition as:

> Functional expense classification: A method of grouping expenses according to the purpose for which costs are incurred. The primary functional classifications are program services and supporting activities. The functional reporting classifications are dependent upon the type of services rendered by the organization.
>
> Natural expense classification: A method of classifying expenditures according to the nature of the expense such as salaries and wages, employee benefits, supplies, and purchased services.

The natural (also referred to as use, object or specific) expense classifications are used in the annual financial statements, described in Chapter 3. Under each of the expense classifications, there is a section titled, Used for. In Chapter 3, information is provided showing the different types of expenses to be included in the natural expense classification.

Functional expenses are presented in columns and the natural expense classifications are presented in rows on the Supplemental Cost Reports (Exhibit C). For expenses benefiting one

cost center, there are usually no difficulties in determining the proper classification for the natural and functional classification. The functional classification problem occurs when the expense benefits more than one cost center. The standard allocation methodologies suggested for allocating functional expenses are described in Standard 4 of this chapter. Suggested statistics, or allocation bases, are listed in the table on 2-11. Providers may substitute a more readily available allocation base as long as it will not increase the costs charged to certain cost centers.

Total expenses categorized under the natural classification in the annual financial statements must reconcile to Schedule 1 of the applicable Supplemental Cost Report (Exhibit C).

Standard 3. Items of cost incurred by the Providers should be classified consistently. To establish this consistency, the following definitions of 'direct costs' and 'indirect costs' should be used when classifying items of cost[i]:

Direct costs are costs that can be traced directly to a cost center and/or program. In general, costs should be treated as direct to cost centers when they are incurred in support of a specific program or cost center. This includes both direct service costs, such as salaries and wages for direct service staff, and administrative and operating costs that can be directly attributable to a certain program or service. See the Example 1 in the box to the right for examples of these two types of direct costs. Direct identification of specific costs (also referred to *as assigning costs*) is the preferred method of charging costs to various functions. If a cost can be specifically associated with a program or supporting service, it should be assigned to that program and/or cost center (direct costs). For example, travel costs incurred in connection with a specific program activity should be assigned to that program. Salaries should be directly assigned to all the appropriate cost centers and/or programs by individuals with varied responsibilities. For example, the salary and expenses of an individual that are related to the direct supervision of a program or specific fund-raising activity rather than the overall organization as a whole should be treated as direct costs. These costs should be directly assigned. If direct identification (that is, assignment) is impossible or impracticable, costs should be treated as indirect and an allocation is appropriate.

Example 1: A ***direct service cost*** might be, for example, the salary of a clinician who provides units of service to substance abuse or psychiatric patients.

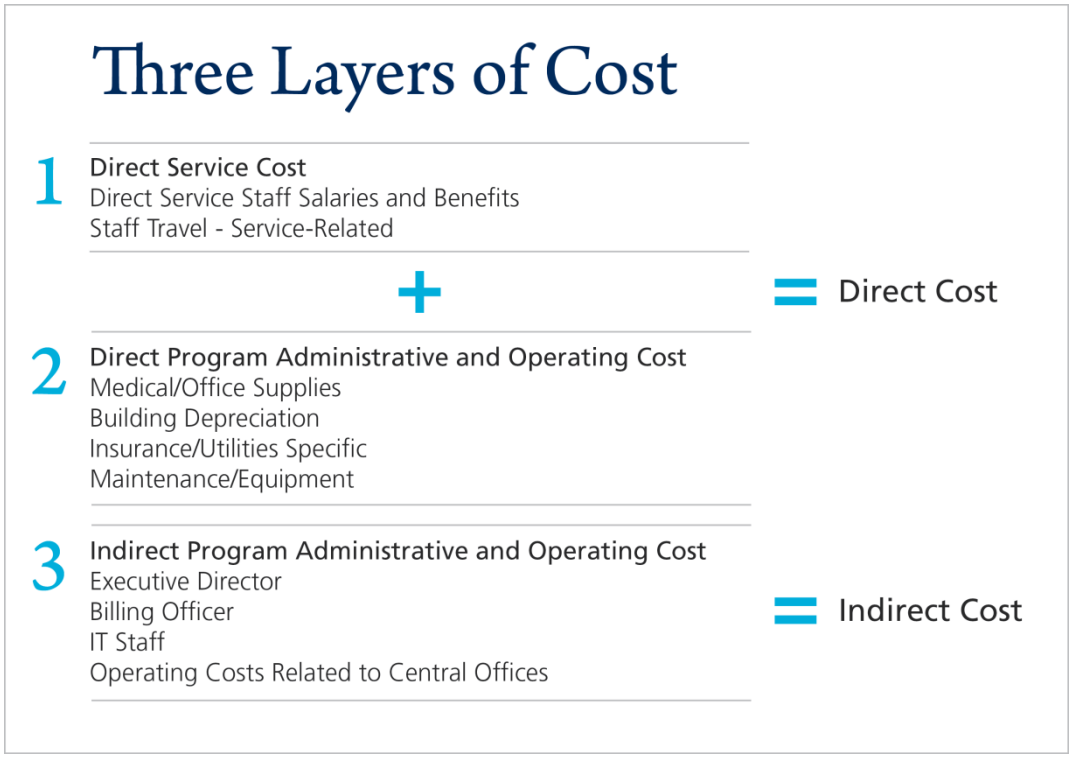
A ***direct administrative or operating cost*** might be the expense of supplies for a patient program. Since this cost is incurred in support of a specific program, rather than benefitting the facility as a whole, this cost would be treated as a direct cost and assigned to the cost center appropriate for that program.

Indirect costs include costs that are not easily assignable to a specific cost center and/or program and are incurred by the organization for a common purpose benefiting the facility as a whole. Indirect costs shall be allocated as outlined in Standard 4. Costs that are incurred in support of all program and service areas across the entire operation of the organization should be treated as indirect costs. Certain administrative operations, such as the Executive Director's office or Accounting department, are necessary for the proper functioning of a program. Since they support all program areas, they are considered indirect costs and should be allocated to the various cost centers and/or programs. In some situations, one item of cost may be partly assignable to a cost center, and partly treated as an indirect cost. See Example 2 in the box to the right for an example of one such item of cost and how to treat it appropriately.

Example 2: An example of an item of cost that would be partly assignable to a cost center, and partly allocated as an indirect cost is an Executive Director of an organization that provides both substance abuse and psychiatric services. Portions of their cost would be treated as a direct cost and indirect (and allocated appr.). See Standard 4 for instructions on allocating costs.

Other accounting professionals and guidelines may refer to direct administrative costs as indirect traceable costs. To remain consistent with prior Guidelines used in Colorado and to avoid any potential confusion over shifting definitions, these indirect, but traceable costs, are classified as direct program administrative and operating costs.

The following chart illustrates the three layers of cost:



The definitions of direct cost (both direct service cost and direct program administrative and operating cost) and indirect cost put forth in this guide should be used to classify items of cost. For instructions on allocating costs to the cost centers, see Standard 4 below.

Certain costs are **unallowable** for reimbursement by OBH and HCPF or only allowable in certain situations. Definitions of these costs, both those that are wholly non- allowable and those that are **unallowable** in certain situations, are as follows:

Advertising and Public Relations Costs. Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are unallowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are unallowable.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are unallowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective.

Alcoholic Beverages. The cost of alcoholic beverages is unallowable.

Bad Debts. Any losses arising from uncollectible accounts and other claims, and related costs, are unallowable unless provided for in OBH contract regulations.

Contingency Reserve. Contributions to a contingency reserve or any similar provision for unforeseen events are unallowable. The term "contingency reserve" excludes self- insurance reserves; pension funds; and reserves for normal severance pay.

Donations and Contributions. Contributions and donations, including cash, property, services, regardless of the recipient, are unallowable.

Defense and Prosecution of Claims Plus Civil and Criminal Proceedings. Costs resulting from violations of or failure to comply with federal, state and local laws and regulations are unallowable.

Depreciation. Depreciation is a method of allocating the cost of fixed assets over a period of time. The period of useful life must be established for the asset taking into account the type of construction, nature of equipment used, historical usage patterns, technological developments, and the renewal and replacement policies.

The computation of depreciation or use allowances *will exclude*: (1) The cost of land; (2) Any portion of the cost of buildings and equipment specially funded or donated by the State or Federal Government irrespective of where title was originally vested or where it presently resides; and (3) Any portion of the cost of buildings and equipment contributed by or for the governmental unit, or a related donor organization, in satisfaction of a matching requirement.

Under cost accounting standards, a plant or equipment asset cannot be depreciated using any accelerated methods. Definition of unallowable methods included below:

> The accelerated methods: There are two methods of accelerated depreciation. They are called accelerated because they provide more annual depreciation expense in the earlier years of the asset's life and less depreciation expense in the later years. In accelerated methods, the amount of annual depreciation is determined using a depreciation rate, which is either fixed or variable. The two accelerated methods are the *declining balance* (DB) method, where the value of the asset at the beginning of each year is multiplied by a fixed depreciation rate, and the *sum-of-the-years'-digits* (SYD) *method*, where the annual depreciation is calculated by multiplying the depreciable cost by a schedule of fractions based on the sum of the digits of the useful life of the asset (e.g., for an asset with a useful life of four years the digits are summed to 10 (4+3+2+1), and the depreciation rate is 4/10 (2/5) for the first year, 3/10 for the second year, 2/10 (1/5) for the third year, and so on).

Once a depreciation method is selected for an asset, the provider must consistently depreciate the asset by this method.

Entertainment Costs. Costs of amusement, social activities, with no public education component and costs relating thereto, such as meals, lodging, rentals, transportation, and gratuities are unallowable.

Fines and Penalties. Costs of fines and penalties resulting from violations of, or failure of the organization to comply with Federal, State, and local laws and regulations are unallowable except when incurred as a result of compliance with specific provisions of an award or instructions in writing from the awarding agency.

Fundraising. Costs of organized fundraising, including financial campaigns, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions are unallowable.

Goods or Services for Personal Use. Costs of goods or services for personal use of the organization's employees are unallowable regardless of whether the cost is reported as taxable income to the employees.

Housing and Personal Living Expenses.

a. Costs of housing (e.g., depreciation, maintenance, utilities, furnishings, rent, etc.), housing allowances and personal living expenses for/of the organization's officers are unallowable as fringe benefit or indirect costs regardless of whether the cost is reported as taxable income to the employees.

   - These costs are allowable as direct costs to sponsored award when necessary for the performance of the sponsored award and approved by awarding agencies.

b. The term "officers" includes current and past officers and employees.

Idle Facilities. The costs of idle facilities are unallowable except to the extent that

1) They are necessary to meet fluctuations in workload; or

2) Although not necessary to meet fluctuations in workload, they were necessary when acquired and are now idle because of changes in program requirements efforts to achieve more economical operations, reorganization, termination, or other causes which could not have been reasonably foreseen. Under the exception stated in this subparagraph, costs of idle facilities are allowable for

a. A reasonable period of time, ordinarily not to exceed one year, depending on the initiative taken to use, lease, or dispose of such facilities; and
b. The idle facility capital cost does not exceed 10% of facility's total capital cost. Capital costs are defined as facility depreciation, facility interest and or facility lease pmts.

Investment Costs. Costs of investment counsel and staff and similar expenses incurred solely to enhance income from investments are unallowable.

Lobbying. Lobbying cost are unallowable except for providing a technical and factual presentation of information on a topic directly related to the performance of a grant, contract or other agreement through hearing testimony, statements or letters to the Congress or a State legislature, or subdivision, member, or cognizant staff member thereof, in response to a documented request made by the recipient member, legislative body or subdivision, or a cognizant staff member thereof; provided such information is readily obtainable and can be readily put in deliverable form; and further provided that costs under this section for travel, lodging or meals are unallowable unless incurred to offer testimony at a regularly scheduled Congressional hearing pursuant to a written request for such presentation made by the Chairman or Ranking Minority Member of the Committee or Subcommittee conducting such hearing.

Maintenance and Repair Costs -Costs incurred for improvements which add to the permanent value of the buildings and equipment or appreciably prolong their intended life shall be treated as capital expenditures, not expenses.

Memberships -Costs of membership in any country club or social or dining club are unallowable.

Personal Gifts. -Costs of personal gifts are unallowable.

Prior Period/Subsequent Period - Costs for services which occurred in a prior or subsequent fiscal year are unallowable. All reimbursement must be for the cost of services rendered during the contract year only. (Based on accrual accounting.)

Rental Costs Under Capital Leases. Rental costs under leases which are required to be treated as capital leases under GAAP, are allowable only up to the amount that would be

allowed had the organization purchased the property on the date the lease agreement was executed, i.e., to the amount that minimally would pay for depreciation or use allowances, maintenance, taxes, and insurance. Unallowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the organization purchased the facility.

Rental Costs Under Sale and Leaseback Arrangements. Rental costs under sale and leaseback arrangements are allowable only up to the amount that would be allowed had the organization continued to own the property.

Rental Costs of Comparable Property. Rental costs are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased.

Retainer Fees. Retainer fees are allowable but must be supported by evidence of bona fide services available or rendered.

Severance Pay. Severance pay, also commonly referred to as dismissal wages, is a payment in addition to regular salaries and wages, by organizations to workers whose employment is being terminated. Costs of severance pay are allowable only to the extent that in each case, it is required by (i) law, (ii) employer-employee agreement, (iii) established policy that constitutes, in effect, an implied agreement on the organization's part, or (iv) circumstances of the particular employment. Costs incurred in certain severance pay packages (commonly known as "a golden parachute" payment) which are in an amount in excess of the normal severance pay paid by the organization to an employee upon termination of employment and are paid to the employee contingent upon a change in management control over, or ownership of, the organization's assets are unallowable.

Travel Expenses. Travel expenses are allowable for only official functions; reimbursement for such expenses may not exceed the most economical and reasonable costs. Reimbursement may not exceed actual costs or per diem for staff members; likewise, cost for official travel may not exceed the limits set by the Internal Revenue Service.

Standard 4. Administrative costs should be assigned or allocated to cost centers and/or programs to the maximum extent practicable; where costs cannot be directly assigned, an allocation methodology must be used.

After using the definitions of direct and indirect costs in Standard 3 to classify items of cost, costs must be either assigned or allocated to the cost centers and/or programs. The methodology for allocating costs varies for direct and indirect; each type of cost allocation is discussed below:

Allocation of Direct Program Administrative and Operating Costs

Direct program administrative and operating costs, such as personnel salaries, fringe benefits, contracted costs, and supplies that benefit and can be traced directly to a cost center and/or program should be assigned directly to the benefitting cost center and/or program. Any administrative and operating expenses that are specific to one cost center and/or program should be directly assigned.

Allocation of Indirect Administrative Costs

In addition to either assigning or allocating the direct and traceable costs to cost centers and/or programs, providers need to identify those costs that benefit the facility as a whole and are not directly traceable to any specific cost center and/or program separately. Indirect costs include administrative costs, such as the Executive Director, Finance/Accounting department, IT department, as well as facility-wide operating expenses such as rent and depreciation, maintenance, and housekeeping. In some cases indirect administrative costs such as rent, utilities, and depreciation will be separately identifiable and will be able to be directly assigned to the appropriate cost center and/or program. Providers will differentiate these facility-wide overhead expenses from those administrative and operating expenses that are directly attributable to programs (Direct Administrative and Operating Expenses). See Example 4 in the box below for an example of the difference between direct administrative and operating costs and indirect costs.

Example 4: An example of a ***direct operating cost*** would be the operating expense of a building that is used to provide services to clients in multiple programs. Since this is an item of cost traceable to several cost centers, it is treated as a direct cost and allocated to the benefitting cost centers based on some statistic, such as square footage.

An example of an ***indirect cost*** would be the operating expense of the central administrative building of a facility. Since this building benefits the facility as a whole, its operating expense would be treated as an indirect expense and allocated to *all* cost centers based on some statistic, such as square footage.

Per OMB A-122, these indirect costs should be statistically allocated down to *all* of the cost centers (unlike direct administrative and operating costs, which are only allocated to the cost centers that incur them).

> "Where an organization's indirect costs benefit its major functions in varying degrees, indirect costs shall be accumulated into separate cost groupings. Each grouping shall then be allocated individually to benefitting functions by means of a base which best measures the relative benefits. Cost groupings shall be established so as to permit the allocation of each grouping on the basis of benefits provided to the major functions. Each grouping shall constitute a pool of expenses that are of like character in terms of functions they benefit and in terms of the allocation base which best measures the relative benefits provided to each function[ii]"

When allocating costs, whether allocating direct costs to multiple benefitting cost centers and/or programs or allocating indirect costs to all cost centers and/or programs, statistics must be documented and maintained in order to distribute the costs.

Acceptable methods for allocating salaries and other personnel costs to different functional expense classifications include:

- Journal entries in accounting system
- Service activity logs or unit increments
- Time study

If a provider uses a different methodology to allocate direct service personnel costs based on time spent, supporting documentation must be maintained and made available upon request.

The following table provides the suggested statistics that providers can use to allocate costs to cost centers and/or programs. Allocation basis must be supported. Providers must maintain and make available supporting documentation of their allocation methodology. T his list is not comprehensive but for illustration purposes only:

Type of Direct or Indirect Expenditure	Suggested Allocation Statistic (When Unable to Assign to One Cost Center)
Direct Service Salaries and Benefits	Service Activity Log - Staff Time
Purchased Services	Service Activity Log - Staff Time
Staff Travel	Service Activity Log - Staff Time
Salaries & Benefits – Direct Service Supervision & Service Administration	Service Activity Log - Staff Time
Supplies	Full Time Equivalents (FTEs)
Occupancy/ Depreciation/ Interest	Square Footage or FTEs
Operation of Plant	Square Footage or FTEs
Human Resources	FTEs
Administration & General	Accumulated Cost
Maintenance & Repairs	Square Footage or FTEs
Housekeeping	Square Footage or FTEs
Central Services and Supplies	Costed Requisitions
Medical Records	Time Spent or Charges

These standards for assigning direct cost and allocating direct and indirect cost to cost centers and/or programs are to be used by all providers. The cost centers that the BHOs will use to classify their functional expenses are listed in Chapter 3, **Special Instructions for BHO Financial Statements**. BHOs must maintain a functional expense classification system throughout the reporting period in order to complete Schedule 1 of the Fiscal and Statistical Supplementary Schedules, Expense Summary by Function.

The cost centers that the CMHCs will use to classify their functional expenses are listed in Chapter 4, Instructions for Completing the CMHC Supplemental Cost Report. The cost centers that the CMHC that also provide SUD services and SUD only providers will use to classify their functional expenses are listed in Chapter 6, Mental Health/Substance Use Disorder Services.

Standard 5. The cost-accounting period is the state fiscal year used by the OBH and HCPF which begins annually on July 1st.

These cost accounting standards will guide the accounting of costs in the Annual Financial Statements (Exhibits A and B), the CMHC Cost Report for CMHCs (Exhibit C), the Cost Report for Mental Health/Substance Use Disorders (Exhibit C) and the Fiscal and Statistical Supplementary Schedules for BHOs (Exhibit H). Please refer to chapters 3, 4, and 6 for specific instructions on completing these forms. Note that the Annual Financial Statements must reconcile to the CMHC Supplemental Cost Report or Fiscal and Statistical Supplementary Schedules.

Chapter 3: Auditing and Financial Reporting Guidelines

CHAPTER 3: AUDITING AND FINANCIAL REPORTING GUIDELINES

The auditing and financial reporting guidelines specify the accounting treatment for assets, liabilities, net assets, revenue and expenses. The guidelines, as well as detailed methods for applying them, are best referenced in the most recent edition of the AICPA Audit and Accounting Guide, Health Care Organizations. Notations are made here of any specific mental health service issues.

Substantially all CMHCs and SUD providers will utilize the American Institute of Certified Public Accountants guide for Health Care Organizations. Certain exceptions to this may exist because they may qualify to use the AICPA Guide for Not-For-Profit Organizations. Providers must decide whether they are a health care entity or a not-for-profit entity in terms of how they will report and track their expenses. Example financial statements can be found in Exhibit A, B, and C that provider greater detail into suggested financial statement reporting options. Which guide to use will require the judgment of the CMHC or SUD provider and their auditor. Excerpts from these guidelines are listed below concerning circumstances under which each guide is utilized. As a general guideline, if the provider receives a majority of its support from public grants and donations from the general public rather than fee-for-services, capitated care contracts or other health care types of payments, they may use the guide for audits of Not-For-Profit organizations. If an organization operates under the Medical Model they should follow the Health Care Audit Guide. Organizations that consider themselves a health and welfare entity should follow the Not-for Profit audit guide. If the Health Care Audit Guide is not utilized, the provider will still be required to present the supplemental information concerning services provided and the costs associated with those services.

Managed Service Organizations and sub-recipients who provide SUD services can refer to Chapter 6 for additional AIPCA guidance.

FOUNDATION FOR ACCOUNTING STANDARDS

The following matrix will be complied by all centers and BHOs and their auditors; if applicable:

Matrix of Requirements

	Cost Principles	**Grant Management "Common Rule"**	**Grant Management "Administrative Requirements"**	**Audit Requirements**
States, local governments, and Indian Tribes follow:	A-87 Cost Principles for State, Local, and Indian Tribal Governments May 2004	45 CFR 92	A-102 Administrative Requirements for Grants and Cooperative Agreements with State and Local Governments 44 CFR 13 August 1997	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2007
Public & Private Institutions of Higher Education (even if part of a State or local government) follow:	A-21 Cost Principles For Determining Costs Applicable To Grants, Contracts, & Other Agreements With Educational Institutions May 2004	45 CFR 74	A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74 September 1999	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2007

Non-Profit Organizations follow:	A-122 Cost Principles for Non-Profit Organizations May 2004	45 CFR 74	A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74 September 1999	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2007
For Profit Organizations	48 CFR 31	NA	NA	NA
Hospitals	1) Medicare Cost Principles in Title XVIII of the SS Act of 1934, 2) Research & Development Costs in 45 CFR 74, Appendix E		A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74 September 1999	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2007

EXPENSE CLASSIFICATIONS

Expense categories will be required to be reported by natural classification on the statement of operations in the annual audit report. The expense categories required are more specific than generally accepted accounting principles and should tie to the supplemental cost report totals as follows:

- Personnel
- Client
- Occupancy
- Operating
- Depreciation and Amortization
- Provision for Uncollectible Accounts
- Professional fees
- Donations

The following shows a detail of what is to be included in each of the above totals:

Personnel

1. ***Salaries***

   Used for: salaries paid to regular employees, full or part-time, and temporary employees other than consultants and others engaged on an individual contract basis.

   Allocation basis: Salaries are charged to functional programs in accordance with cost accounting standards laid forth in Chapter 2.

2. ***Payroll Taxes***

   Used for: FICA taxes and compensation insurance premiums payable by employers under federal, state and local laws.

   Allocation basis: payroll taxes are charged to functional programs on the same basis as salaries.

3. ***Employee Benefits***

   Used for: amounts paid and accrued for employee health insurance and retirement benefit plans, or cafeteria plans.

   Allocation basis: employee benefits are charged to functional programs on the same basis as salaries.

Client

1. ***Client-Salaries***

   Used for: salaries paid to clients.

   Allocation basis: client salaries are charged to functional programs based on the amount of time spent on each.

2. ***Client-Taxes and Benefits***

   Used for: amounts paid for client taxes and benefits.

   Allocation basis: taxes and benefits are charged to functional programs on the same basis as salaries.

3. ***Client-External Doctors, Clinics and Hospitals***

Used for: amounts paid to external doctors, clinics and hospitals for services t o clients.

Allocation basis: these expenses are usually program specific and are not allocated among different functional programs.

4. ***Client-Food***

Used for: only the cost of food is charged to this account.

Allocation basis: usually food expense is charged directly to a particular program and allocation should not be necessary. Food cost for administration activities such as board meetings are charged to administration.

5. ***Client-Medical Supplies and Laboratory***

Used for: amounts paid for medical supplies and laboratory expenses.

Allocation basis: these expenses are usually program specific and are not allocated among different functional programs

6. ***Client-Medications***

Used for: amounts paid for medications used by clients.

Allocation basis: these expenses are usually program specific and are not allocated among different functional programs.

7. *Client-Purchases from Other Providers*

Used for: expenses for purchasing services from other providers that provide same or similar services. Examples are: when an agency operates a residential program for some of their clients and also purchases residential services from other providers for some of the clients with special needs.
Allocation basis: expenses in this classification are always program specific and allocations are not used.

8. ***Client-Supplies and Travel***

Used for: amounts paid for supply type items used by clients and cost of transporting clients to and from programs. Examples are recreation and craft materials.

Allocation basis: supplies and client travel are, for the most part, program specific and should be identified as such when the expense is initially recorded.

Occupancy

Janitorial
Maintenance and supplies
Insurance, property
Rent and real estate taxes
Utilities

Used for: expenses resulting from an agency's occupancy and use of owned, rented, lease or donated building and offices.

Allocation basis: occupancy costs are charged to functional programs based upon the functions of the individuals' using the space involved. Example: An office building with 2,000 square feet, 1,000 square feet is used by Administration staff and 1,000 square feet is used by Case Management staff. All of the associated occupancy costs would be equally charged to the functional programs of Administration and Case Management.

Operating

1. ***Operating-Dues, Fees, Licenses and Subscriptions***

   Used for: amounts paid for memberships in other organizations, expenses for publications, advertising, subscriptions, bank fees, collection fees, licenses and survey fees.

   Allocation basis: expenses for dues, fees, licenses and subscriptions should be charged to the program benefiting from the expenditure.

2. ***Operating-Equipment Rentals, Lease and Maintenance***

   Used for: costs of renting or leasing and maintaining equipment such as computers, office equipment and program equipment.
   Allocation basis: costs are allocated based upon the actual use of the equipment according to the functions of the individuals using the equipment. Example: maintenance cost for a computer used only by administrative personnel would be charged to administration. If the computer is used equally by administrative staff and case management staff, the maintenance cost is equally prorated between the functional programs of administration and case management.

3. ***Operating-Insurance***

   Used for: the cost, paid or accrued, of premiums for insurance contracts to reimburse the agency for revenue or property loss caused by various types of events over which the agency has no control, i.e., fire, theft, content and liability. These costs could be administrative or program and should be allocated based upon the

following criteria:

a. Premiums directly identifiable with one program service should be charged to that program.
b. Premiums, which provide coverage for several or all program services, should be allocated based upon:

    i. Premiums covering land and buildings should be charged on a basis of square footage of occupancy.
    ii. Premiums based on payroll hours should be charged on a payroll hour basis. Premiums based on number of persons served should be charged on a person served basis.

4. ***Operating-Interest***

Used for: expenses incurred for borrowing money. The interest should be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's- length transaction in the money market when the loan was made.[iii]

Allocation basis: interest paid for facility purchases or equipment purchased for a facility are a direct expense to that facility and should be charged to that facility's operating expense. Interest paid for general-purpose working capital or other general- purpose operations shall be considered administrative expenses.

5. ***Operating-Office Supplies***

Used for: paper, pens, pencils, file folders, computer and copier supplies, and other office type supplies. Low cost furniture and equipment that is not capitalized is also charged to this category.

Allocation basis: supplies are for the most part program specific and should be identified as such when the expense is initially recorded. However, another approach is to charge all office supplies to an administrative cost center and allocate to other functional programs using some allocation method that approximates actual usage of supplies.

6. ***Operating-Postage, Printing and Reproduction Costs***

Used for: postage, internal and external printing and reproduction costs for such items as brochures, manuals and pictures.

Allocation basis: postage, printing and reproduction, are usually not readily identifiable with a particular program and have to be allocated to all programs using some basis that approximates actual usage.

7. ***Operating-Telephone and Pagers***

   Used for: telephone and other electronic communication expenses. Costs associated with leasing or purchasing a communication system are reported in the object classification, equipment rental, lease and maintenance.

   Allocation basis: if the expense is identifiable (through examination of telephone statements), then it should be charged directly to the appropriate functional program. Otherwise, the expense should be allocated based upon a reasonable basis such as the number of FTEs.

8. ***Operating-Travel, Conferences, and Staff Development***
   Used for: expenses of staff travel including mileage allowances, hotel, meals and incidental expenses. Expenses associated with providing formal internal and external staff development programs; including training classes, meeting space and equipment rentals.

   Allocation basis: these costs are usually program specific and the associated costs should be charged to the appropriate functional program when the expenses are initially recorded. When allocations are necessary, they need to have a verifiable basis. Example: costs of training programs provided for all of the organizations' employees would be allocated based upon the number of employees or costs of the functional programs.

9. ***Operating-Vehicle Fuel, Oil, Lease and Maintenance Costs***

   Used for: expenses of agency owned or leased vehicles.

   Allocation basis: these costs should be allocated based on actual use or the salary allocation of the employees using the vehicles. Example: If a vehicle is used 100% of the time by the executive director, 100% of the vehicle cost is assigned to administration. If the staff to whom the vehicle is assigned, spends 20% of their time working in administration and 80% working in case management, the cost of the vehicle should be allocated in the same manner. For pool vehicles (used by any agency employee), vehicle use logs can be used to charge the cost to the functional programs.

Depreciation and Amortization

Used for: recording the depreciation and amortization expense for depreciable assets. Examples are computers, furniture, vehicles and buildings.

Allocation basis: The provider can use the allocation statistic in Chapter 2, or assign directly; for example, depreciation expense for fixed assets benefiting two or more function programs is allocated based upon the functions of the individuals using the assets.

Provision for Uncollectible Accounts

Used for: to record the amount of estimated uncollectible portions of accounts receivable.

Allocation basis: Uncollectible expenses are charged to the various functional programs based upon a verifiable basis which reflects a proportional relationship between revenues generated and loses due to un-collectability.

It should be noted that according to Accounting Standard Update 2011-07, health care organizations that recognize significant amounts of patient service revenue at the time services are rendered even though the organizations do not assess a patient' ability to pay, would show the provision for uncollectable accounts as a deduction from revenue on the audited financial statements. Organizations that do assess a patient's ability to pay would still show the provision for uncollectable accounts as an expense in the audited financial statements. Careful consideration should be given to the classification of the provision for uncollectable accounts to determine if the amount should be shown as a deduction from revenue or an expense.

Professional Fees

Used for: fees and expenses of professional practitioners and consultants who are not employees of the agency and are engaged for specified services on a fee or other individual contract basis.

Examples: auditing, accounting, computer services, management consultants, legal.

Allocation basis: professional fees should be charged to the functional program benefiting from the services. Audit, accounting and legal are administrative in nature and should be charged to administration. The only exception is when a reasonable, practical and verifiable basis exists for charging them to another function program e.g., legal services secured specifically for residential services, and the applicable legal fees are separately identified.

Donations (Donated In-Kind)

Material and building space
Volunteer services
Hospital care
Psychiatric Medications

Used for: recording the value of donations for material and building space, volunteer

services, hospital care, and donated psychiatric medications.

Allocation basis: donations are mostly program specific and should be charged to the program benefiting from the donation. For donations benefiting two or more programs, the allocation basis would be the same one used if the time or service was purchased. For example, donated use of a building and more than one of the agency functional programs uses the building.

Related Party Transactions

For CMHCs and funded SUD providers, all transactions with related parties (i.e., Parent Company/Management Fees, lease expenses, etc.) must be disclosed on Exhibit D. If no fair market value? (FMV) is readily available for a related party transaction, this must be noted on the schedule.

Unallowable Costs

For rate setting purposes, certain costs identified in Chapter 2, are not allowable. The accounting system needs to be established for these costs to be readily identified so they can be segregated from the allowable cost categories.

Auditing Guidelines

These auditing and reporting guidelines have been prepared to assist the independent public accountant (auditor) in examining and reporting on the financial statements of CMHCs/ funded SUD providers and BHOs/MSOs in Colorado. OBH and HCPF encourage the maximum possible uniformity in financial reporting.

The actual conduct of the financial audit is governed by generally accepted auditing standards and other authoritative pronouncements of the profession particularly the AICPA's Health Care Organization Audit Guide, as well as the requirements contained elsewhere in this guide.

OBH and HCPF require that the independent auditor of the CMHCs'/funded SUD and BHOs' financial statements have current AICPA peer review documents on file. The CMHCs and BHOs must follow the cost accounting and auditing guidelines outlined in OMB Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. The auditors in conjunction with the organization are responsible for determining if the organization is subject to A-133 audit requirements. If applicable, the auditor will be required to follow the Generally Accepted Governmental Audit Standards (GAGAS) in the conduct of the audit. Once again, the entity and its auditor will still be required to provide the supplemental information and related accountants' reports as contained in the example financial statements included herein. OBH/HCPF guidelines, as outlined in this section, assume that the auditor will follow those standards and pronouncements.

Financial and Supplementary Cost Reporting Guidelines

The annual audits of financial statements and the agreed upon procedures of the supplementary cost reports with respect to the statistical system are the primary documents used to calculate the service cost and to monitor the cost reimbursement system and the encounter systems. The audits provide credibility to the reimbursement system and the encounter systems presented to the Legislature, as financial statement information is subjected to independent audit procedures, including testing of controls and validity of supporting documentation. Required financial statements are presented as Exhibits A, B, E and F; however, if changes are made to the AICPA Healthcare Organization Audit Guide, conforming changes must be made to the financial statement presentation.

Authoritative pronouncements of the accounting profession dictate the form and substance of the attestation opinion for the supplementary cost data.

For CMHCs and SUD Providers only, the Supplemental Cost Report, is used in part to calculate the Provider's base unit cost, as included in Exhibit C. To provide a standardized testing process, the auditor will complete the prescribed testing noted below. The results of the identified testing must be summarized in an Agreed Upon Procedures Opinion from the auditor to the CMHC or SUD Provider. The Agreed Upon Procedures Opinion from the auditor for the CMHC's and SUD provider's Supplemental Cost Schedules should specifically address the following steps:

1. Obtain a listing of all encounters generated during the FY (with client id, client name, number of units, location, date of service, primary diagnosis code and CPT/HCPCs code):

A. The auditor will select a one CPT/HCPS code randomly and identify location information for all the encounters tied to this selected code

1) Based on location of service for all the encounters related to the single selected CPT code;

a. Verify that the total # of units for the selected CPT/HCPCS code are accurately reflected on either Schedule 3 or 3A based on the service locations identified.

b. Confirm the total units for the selected CPT/HCPCS code reported on Schedule 3 and 3A combine to match the total units for the CPT/HCPCS code selected in 1A. above.

B. Select 30 encounters randomly (with client id, client name, number of units, location, date of service, primary diagnosis code and CPT/HCPCs code) from item 1 above.

1) Trace the identified information to the medical record for the 30 selected services to confirm the existence of the service

provision.

Management Letter

The auditor is required to communicate to the board of directors any material weaknesses or significant deficiencies in accordance with the Statement on Auditing Standards 115. In addition, oftentimes auditors communicate other control matters referred to as management letters.

OBH / HCPF require copies of SAS 115 communication and management letter along with a copy of the response by the management to its Board.

Care should be exercised by the auditor to ensure that management letter comments which represent findings to be reported under the requirements of OMB Circular A-133 are appropriately included in the applicable report.

Third-Party Liability (BHOs ONLY)

For services reported in any encounter data submission, including units of service reported on Schedules 4 and 4A of the CMHC Supplemental Cost Report (see Chapter 4 for more details), where the encounter record had a service date between 7/1/XXXX and 6/30/XXXX, BHOs should submit the amount of payment made by any and all responsible third party or parties that reduced the amount that the BHO and CMHC paid or would have otherwise been obliged to pay for the service present on the encounter record.

The format of the Third Party Liability (TPL) reporting is presented in Exhibit I of the Appendix. Only BHOs need to complete Exhibit I, CMHCs are not required to report TPL.

The BHO needs to report the amount of TPL for each of the following TPL types:

1) Claim-Specific Adjudication: The accumulated dollar amount collected from each third party based on the specific claims.
2) Post-Pay Adjudication: A lump sum amount of money collected from third parties by the end of a time period without specific claims.
3) Post-Pay Adjudication for Pre-Paid Entities: Money collected from third parties for BHO sub-contractors.

The reporting format in Exhibit I allows for the BHO to report TPL for both the prior and current fiscal year. The following table determines when a specific TPL amount should be reported (DOS=Date of Service; DOP=Date of Payment):

Fiscal Year XXXX	
Prior Year	
DOS	6/30/XX and Prior
DOP	1/1/XX-12/31/XX
Current Year	
DOS	7/1/XX - 6/30/XX
DOP	7/1/XX - 12/31/XX

The TPL reported by the BHOs will be used to inform rate-setting, and as such must be certified to be accurate to the best of the BHO's knowledge.

Special Instructions for BHO Financial Statements

BHOs are required to provide separate annual financial statements and supplementary information as required by the Department of Health Care Policy and Financing.

BHOs are expected to have adequate accounting and information systems in place to provide the data needed to meet the accounting and reporting requirements under the capitation contract. Should there be any conflict between the contents of these Accounting and Auditing Guidelines and that contract; the terms of the contract will take precedence.

The BHO Chief Financial Officer or the Chief Executive Officer must affirm that all service cost reported is for services that are covered benefits under the capitation contract and that all administrative costs reported are economical, efficient, and directly necessary for the Colorado Medicaid eligibles who are enrolled under the capitation contract, in compliance with 42
CFR438-600 et seq. Costs for services not covered under the contract or that are not necessary administration benefiting Medicaid eligible enrollees shall not be considered allowable BHO costs in the financial statements or cost reports.

Fiscal and Statistical -- Supplementary Schedules:

The supplementary schedules consist of three pages.

1. Expense Summary by Function;
2. Clients Receiving Services by Function and Inpatient Statistics;
3. Expense Summary by Cost Center and Eligibility Type;

(See Exhibit H in the Appendix for current copies of the forms.)

The BHO auditor will complete the prescribed testing below.

For page 1 of the supplementary schedule:

The auditor will verify the total expenditures to the audited financial statements

For Page 2 of the supplementary schedule:

- Pick 3 modalities to agree the count of clients served back to the raw data files. This would verify that the count of clients served was supported by a file showing each individual patient receiving services.
- Get total unduplicated member served count and agree it to the raw data file.

Instructions for each schedule are as follows:

Schedule 1: Expense Summary By Function: The Total Expenses applicable to services provided to Medicaid Clients should tie to the financial statements. The service functions, or columns [3] through [15], are based on the cost centers described by the Department of Health Care Policy and Financing.

a) The expenses should be reported through the following cost centers:

State Plan
1. Inpatient
2a. School-based
2b. Home-based
2c. Children Residential Services
2d. Other encounter-based services with RVU weights
3. Other State Plan Services without RVU Weights

Non-State Plan (B3 waiver services)
1. Clubhouse & Drop-in centers
2. Vocational services
3. ACT services
4. Prevention & Early intervention
5. Adult Residential services
6. Intensive case management
7. Respite Care
8. Recovery Services

The definitions for these services are provided in the Uniform Service Coding Standards document.

BHOs are required to allocate costs in a consistent manner, as stated in Standard 4 in Chapter 2 of this document. BHOs must maintain and supporting documentation of the allocation methodology or methodologies used and make such documentation available upon request by HCPF.

A. Inpatient: If a BHO has contracted with a hospital for services other than Inpatient Services, enter those services in the appropriate column.

- Some BHOs are paying per diem rates that include physician services;

others pay physician services, case management, or other services separately. If material, show these costs separately on line 2a of the schedule.

- A schedule of the vendors included in this section, or other appropriate documentation, to support this allocation.

B. Non-Community Mental Health Service Providers: Enter contracts with private practitioners and other providers of residential and ambulatory care in the appropriate columns. All costs should be limited to services provided under the contract to Medicaid enrolled individuals.

- A schedule of the vendors included in this section, or other appropriate documentation, to support this allocation.

C. Community Mental Health Centers: Enter all services provided by Community Mental Health Centers in this section. BHOs that consist of more than one CMHC should combine the activities of the CMHCs on one line and report the total dollars distributed to the CMHCs, by functional areas.

- Documentation of the cost accounting methodology used to allocate costs to the specific functions, including administrative costs incurred by the CMHC that are contractually delegated BHO administrative function must be maintained and be available for review.

D. Central Administrative Expenses: The main purpose of this section is to capture summarized costs generated by the Limited Liability Companies (LLC) or allocated from a contractor that provides administrative functions on behalf of the BHO that are directly necessary for the operation of the BHO as outlined in the BHO contract. Items D1, 2, 3, and 4 should be under the Central Administration column.

- D1 *LLC, Corporate Expenses*: Enter summarized administrative and management costs incurred directly by the BHO.
- D2 *Other Administrative Purchase of Services*: BHOs should enter expenses specific to the MCP contract, with external entities, on this line. Examples include any purchased administrative services that are directly necessary for the operation of the BHO as outlined in the BHO contract.
- D3 *Other Internal Central Admin Expenses*: Enter other items on this line. Separately, and briefly, describe these expenses in an addendum to this schedule.
- D4 *Direct Care Program*: The BHO or the LLC may be operating a direct care program for the benefit of the members of the LLC or partnership and these costs should be entered into the appropriate column. Be prepared with a brief description of the program, including its primary function and location, to support the allocation.

E. Non-Cash Expenses and Accrued Expenses:

- E1 *Depreciation:* a detailed schedule should be available at the site review.
- E 2a, 2b, 2c *IBNRs*: a detailed schedule should be available at the site review.

Provision of documentation authorization processing and actuarial information used to accrue expenses entered on this line.

- E3: *Provision for Bad Debt*
- E4 *Other:* A detailed schedule to support the allocation should be available at the site review.

F. Unallowable Expenses: All expenses that are unallowable by HCPF/OBH, as defined in Chapter 2, should be reported on this line

G. Total Expenses: Columns [2] through [15] should equal the total in column [1].

Schedule 2: I. Clients Receiving Services by Function: Report the number Medicaid clients receiving services in the same functional areas that correspond with the expenses reported on Schedule 1, the page that captures the expenses by function. A client can receive services in more than one functional area by the same provider (columns), and receive services from different providers (rows).

- Column [1]: This column represents the unduplicated count of clients served in each of the different provider categories.
- Column [1], item E: This box represents the net unduplicated count of clients seen, regardless of which provider category serves them. For BHOs that serve multiple service areas, the number should represent the "combined" unduplicated count for each of the service areas included in the BHO contract. Or, unduplicated by service area and then combine those numbers.

Schedule 2: II. Inpatient Statistics: The purpose of this section is to provide documentation about inpatient utilization. The average costs should tie to the expenses reported on page 1.

- The age of the patient for the "Inpatient Days by Age" portion of Inpatient Statistics should follow HCPF instructions, described below. It is possible for a client to be in one age category at admission and in another at readmission.
- HCPF instructions state:
    - Open Cases -- Age is determined on July 1 of the reporting year.
    - New Admission & Readmissions -- Age is determined on the admission date of the reporting year.
    - Clients remain in the age categories as described above until the end of the treatment episode or the end of the fiscal year, whichever comes first.

Additional inpatient information:

- Total Inpatient Census Days: the basis for this information is claims paid.
- Prepare a detailed schedule of the days by specific hospital for review at the site visit.
- Inpatient Days by Age: these days should tie the census days section.

- The appropriate clinical person should analyze the total re-admissions. Be prepared to discuss the readmissions during the BHO review visit.
- The discharge averages
  - Discharge average LOS. To calculate this amount, the BHO must pull all days associated with clients discharged during the fiscal year and divide it by the total number of discharges.
  - Cost ($s) is the cost per discharge. To calculate this amount, the BHO must pull all costs associated with clients discharged during the fiscal year and divide it by the total number of discharges.

Schedule 3: Expense Summary by Cost Center and Eligibility Type: This section corresponds with the medical expenses reported on Schedule 1. The total medical expenses reported on Schedule 1 should tie with the total medical expenses reported on Schedule 3. Schedule 3 is broken out in the following way:

A. Claims Expenditure: The BHO should report the medical cost spent on claims paid Fee-For-Service. The BHO should separate this cost by the client's eligibility type and the cost center.

B. Downstream PMPM Reimbursement: The BHO should report any expenditures associated with a downstream arrangement. These expenditures should reflect only the net medical cost component of these arrangements; any non-medical cost component should be reported under the administrative information or footnoted. The BHO should separate these cost by the client's eligibility type and the cost center.

Notes:

- Include only costs for medical services that generate claims or encounters.
- Schedule 3 should tie to the medical expenses reported in Cost Categories A, B, and C on Schedule 1. Non-medical costs should not be reported on Schedule 3.

Chapter 4: Instructions for the Supplemental Mental Health Cost Report

CHAPTER 4: INSTRUCTIONS FOR THE SUPPLEMENTAL MENTAL HEALTH COST REPORT

In addition to completing financial statements (per Exhibit A), the CMHCs will also complete a Supplemental Cost Report (Exhibit C) that requires detailed reporting of expenses and utilization. These schedules will capture the data necessary to calculate the base unit cost for each CMHC, which will be used in the RVU pricing methodology. As described in Chapter 2, Standard 2, the provider will perform an expense classification process to separate expenditures into **functional cost centers**. This functional classification will be used to summarize items of costs (tied to the audited income statement) for each CMHC and allow for assignment or allocation of salaries and wages, staff travel costs, purchased services, and direct operating costs to the appropriate functional cost centers on the Supplementary Cost Report. The functional cost centers defined on Schedule 1 of the Supplemental Cost Report are as follows:

See Example 3 in Chapter 2 for the difference between direct costs that can be assigned to one cost center and direct costs that have to be allocated to multiple cost

Note: If you are a mental health and substance abuse provider refer to Chapter 6 for the applicable cost report.

Column 1- Full Time EQV (FTEs):
A non duplicative count of all Full Time Equivalent employees based on an annual number of hours worked.

Column 2 - Indirect (Not Traceable to Direct Cost Center):
An administrative reporting unit is necessary to capture organizational-wide costs such as:

The Executive Director, CFO, Accounting, IT, and other administrative functions essential to the operation of the organization are indirect staff. Expenses that are not directly traceable to a cost center will be reported discretely in this cost center and allocated out to the direct service cost centers.

See the table in Chapter 2 for that suggests statistics that the provider should use to allocate costs.

The provider will allocate direct service costs that cannot be assigned to one cost center based on the allocation methodology outlined in Chapter 2, Standard 4. Personnel costs (salary, wages, benefits, etc.) for direct service employees must be allocated using time spent. Once the provider has completed the functional expense classification to assign or allocate all direct costs to the different cost centers, the provider should follow the instructions to allocate these costs to the functional programs, establishing the total functional expense for each identified program on the schedule.

Column 3 Encounter-based Mental Health Services with RVU Weights:
For costs related to the provision of outpatient mental health services which generate encounters with clearly defined Mental Health CPT/HCPCS billing codes and have

established RVU weights assigned to them.

Column 4 - Encounter-based Mental Health Inpatient Hospital Claims without RVU Weights:

For costs related to the provision of mental health inpatient services or in an Acute Treatment Unit (ATU) which generate encounters (irrespective of billing code), but do not have established RVU weights assigned to the codes.

> Note: The cost of providing encounter-based services with RVU weights such as professional services in an inpatient setting (therapy, medication management, evaluations, etc), are to be classified under the **Encounter-based Mental Health Services with RVU Weights** cost center, noted in A. above.

Column 5 - Encounter-based Residential Services without RVU Weights:
For costs related to the provision of mental health residential services in a 24 HR Supervised Residential program which generate encounters, but do not have established RVU weights assigned to them.

These residential services are provided in Short-Term Residential Treatment Facilities, Long- Term Residential Treatment Facilities, or Acute Treatment Facilities.

Note: The cost of providing encounter-based services with RVU weights such as professional services in a residential setting (therapy, medications management, evaluations, etc) are to be classified under **the Encounter-based Mental Health Services with RVU Weights** cost center, noted in A. above.

Column 6 -Encounter-based Other Mental Health Services without RVU weights and Non-encounter based Mental Health Costs (OTHER):
For costs related to other mental health services that do not have established RVU weights assigned to them. Costs associated with any of the following services that generate encounters, but do not have RVU weights: OBH Early Childhood direct services, Other Capacity funded programs, pharmacy encounters, emergency encounters (w/o RVU weights) and lab encounters. For costs related to other mental health programs that do not generate encounters. Costs associated with retail pharmacy or contracted lab services, psychiatric medications and other services that are funded wholly by outside grantors, and other non- encountered services such as housing services.)

Column 7 -Non-encounter based BHO Administrative Costs:

For costs related to the administration of the Medicaid Capitation Program that have been subcontracted to the CMHC outside of the existing contract requirements from the Behavioral Health Organization. The CMHC will be reimbursed for the cost of these activities by the BHO as part of the administrative component of the capitation rate to the BHO. An agreement will exist between the BHO and the CMHC to perform these services

necessary for the administration of the BHO. Costs related to any type of face-to-face service **should not** be reported in this cost center.

Column 8 - Unallowable costs:
For all costs that are identified as unallowable for the calculation of the Base RVU cost. These costs are detailed in Chapter 2.

SCHEDULE 1 – TRIAL BALANCE OF EXPENSES (by Natural Classification)

Schedule 1 records the trial balance for the provider at the end of the reporting period. The costs reported on Schedule 1 must come directly from the Provider's trial balance, which includes all activities conducted by the reporting entity. **The standard preprinted line numbers and cost center descriptions cannot be changed or modified by the Provider.**

Line 1 – Total Direct Program Staff FTE and Salaries:

Line 1, column 1 should be used to record all direct program staff full-time equivalents
(FTEs). An FTE will be based on annual number of hours worked/2080
hrs.

Line 1, column 3-9, should be used to record the salaries, wages, and other non-fringe compensation for the direct care program staff incurred by each functional cost center. This line includes all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" as defined in Chapter 3.

Line 2 – Total Administrative Staff FTE and Salaries:

Line 2, column 1 should be used to enter the FTE's and salaries for the Administrative staff who are not directly assignable to a clinical program or facility. An FTE will be based on annual number of hours worked/2080 hrs.

Line 2, column 2 should be used to record the salary, wages and other non-fringe compensation for those individuals reported in column 1. This line includes all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" as defined in Chapter 3.

NOTE 1: The total FTE for Direct Program Staff + Administrative Staff = the total Agency FTE as of June 30, 2013.

NOTE 2: Acceptable methods for allocating salaries for lines 1 and 2 to different functional expense classifications include either:

- Journal entries in accounting system; or

- Service activity logs; or
- Time study.

Line 3 – Total Personnel

Line 3 automatically calculates the Total Personnel columns 3-7; there is no data entry on this line.

Lines 4 – 10 – Natural Classification of Expenses:

Lines 4 – 10, columns 2-8 will contain all non-compensation expenses by natural classification.

- Provider should report costs which cannot be allocated directly to a direct service cost center (Indirect expenses only) in column 2 by the appropriate line definition. (See Chapter 2).
- For columns 7 & 8– Non-Encounter Based BHO Administrative Costs and Unallowable Costs, these costs as defined in Chapter 2 are accumulated by natural classification in the respective columns (See Chapter 2).
- For columns 3-6, the provider should report all costs that are charged or allocated directly to the direct service cost centers that have not been recorded in column 2, 7 or 8. The costs should be classified by the appropriate line definition (See item K. above.).

NOTE: The Natural Classification definitions (lines 1-10) and specific expense item roll ups are detailed in Chapter 2.

Line 11, columns 2-8– Total Direct Cost:

Line 11, columns 2-11 will automatically sum. No data entry required.

Line 12, column 2 – Allocation of Indirect Cost to Functional Programs:

Line 12, column 2 – is the amount of indirect cost to be allocated to the functional programs to obtain full functional program cost. It is the negative of the total expenses for column 2 located on line 11.

Cost allocation for line 12, across columns 3-8 must be based on a sound methodology for allocation. This line will total to $0 in column 9, as it is an allocation to offset the amount in line 12, column 2.

Documentation of the allocation methodology is required. The provider must select at the bottom of Schedule 1, which allocation method is being used to allocate the indirect costs across the functional programs. *If the Other allocation is used, an explanation of the allocation methodology is required.*

Line 13 – Total Cost:

Line 13 automatically computes the total functional program cost in each column by adding Line 11, Total Direct Cost and Line 12, Indirect Cost Allocation.

NOTE: Line 1 and Lines 3 – 11 (across columns 2-8), as summed in column 9 (**Total Cost**) should tie by the natural expense classification line item to the audited expenses shown on the CMHC **Statement of Operations.** *Column 9 is an auto sum column (cross totaling columns 2-8), no data entry required.*

Line 14 – Unduplicated Client Count:
Unduplicated Client Count line provides the denominator by program to calculate the average cost per client

- Providers are to report the total number of clients served by program. Client counts may be duplicated by program.

Line 15 – Cost per Unduplicated Client

- Average Cost per Client is an automatically calculated field (Total Cost divided by Unduplicated Client Count)

SCHEDULE 2A – SUPPLEMENTAL SCHEDULE FOR COLUMN 6

Schedule 2A Section I please list each individual expense that is greater than or equal to $50,000 that was included in Column 6 of Schedule 1. Section II please put the total of all expenses that were less than $50,000 that were included in Column 6 on Schedule 1.

SCHEDULE 3 – UTILIZATION (ENCOUNTER-BASED MENTAL HEALTH WITH NON-FACILITY RVU WEIGHTS)

Schedule 3 collects utilization data for *Encounter-based Mental Health Services with RVU weights*, as defined above, for all services provided in a Non-Facility setting. All services provided outside of the Community Mental Health Center should be considered non- facility place of service, and will use non-facility RVU weight.

Units of service reported on Schedule 3 should only be related to the costs reported on Schedule
1, from Column 3 Encounter-based Mental Health Services with RVU weights.

In order to complete schedules 3, the provider must track each encounter or unit of service by the following data elements:

1. Direct Care Provider Information (Employee I.D., Education level, etc.)
2. Client Information
3. Service Information
    a. Primary Diagnosis code b. Service/revenue code
    c. POS code
    d. Date of Service
    e. Number of Units

From the service encounter data, providers will track service delivery by utilization over the course of the entire fiscal year for input into Schedules 3 and 3A. The following instructions describe how Schedule 3 organizes the utilization data.

Column 1 – Total Units for Mental Health

Providers should report all *mental health encounter able units of service with an RVU weight* provided in a Non-Facility setting by the CPT/HCPCS codes listed in lines 1-191. Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as defined in this column. Line 192 automatically calculates the total units; the provider should not enter any data in this line.

Column 2- Total Relative Value Units Mental Health

All rows in this column are calculated automatically. The calculation is the Column heading "Non-facility RVU Weight" X the number of units in Column 1. (i.e. Line 2 = 0.14 (RVU weight) X units from line 2 Column 1).

SCHEDULE 3A – UTILIZATION (ENCOUNTER-BASED MENTAL HEALTH SERVICES WITH FACILITY RVU WEIGHTS)

Schedule 3A collects utilization data for *Encounter-based Mental Health Services with RVU weights*, as defined above, for all services provided in a Facility setting. All services provided in a Community Mental Health Center should be considered facility place of service, and will use facility RVU weight.

Units of service reported on Schedule 3A should only be related to the costs reported on Schedule 1, Column 3 Encounter-based Mental Health Services with RVU weights.

In order to complete schedules 3, the provider must track each encounter or unit of service by the following data elements

1. Direct Care Provider Information (Employee I.D., Education level, etc.)
2. Client Information
3. Service Information
    a. Primary Diagnosis code
    b. Service/revenue code
    c. POS code
    d. Date of Service
    e. Number of Units

From the service encounter database, providers will track utilization over the course of a year for input into Schedules 3 and 3A. The following instructions describe how Schedule 3A organizes the utilization data.

Column 1 – Total Units for Mental Health

Providers should report all *mental health encounter able units of service with an RVU weight* provided in a Facility setting by the CPT/HCPCS codes listed in lines 1-191. Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as defined in this column. Line 192 automatically calculates the total units; the provider should not enter any data in this line.

Column 2- Total Relative Value Units Mental Health
All rows in this column are calculated automatically. The calculation is the Column heading "Facility RVU Weight" X the number of units in Column 1. (i.e. Line 2 = 0.14 (RVU weight) X units from line 2 Column 1).

SCHEDULE 4 BASE UNIT COST CALCULATION

Schedule 4 automatically calculates the provider-specific base unit cost for mental health. The provider should not enter any data on Schedule 4.

At the top of Schedule 4, the Total Allowable Cost for Encounter-Based Mental Health Services is pulled in from Schedule 1, Column 3, Line 13. Next, the Total Relative Value Units for mental health are pulled in from Schedule 3, Column 2, Line 192 and Schedule 3A, Column 2, Line 192. Then, the Base Unit Cost for Mental Health is automatically calculated by dividing the Total Allowable Cost for Encounter-Based Mental Health Services by the Total Relative Value Units for Mental Health.

Column 1 – Mental Health Cost per Non-Facility Unit of Service
Column 1 automatically calculates the cost of providing a unit of service in a Non-Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Non- Facility RVU weight.

Column 2 – Mental Health Cost per Facility Unit of Service
Column 2 automatically calculates the cost of providing a unit of service in a Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Facility RVU weight.

SCHEDULE 5-RESIDENTIAL/INPATIENT SERVICES DETAIL

Schedule 5 requires providers to report information about the residential/inpatient facilities in greater detail. The provider should list only as many residential/inpatient facilities as it operates.

Column 1-Name of Facility:
List the names of all the residential/inpatient facilities that the CMHC operates. List one facility per line and be as specific as possible.

Column 2-Type of Facility:
Specify the type of facility (Residential, ATU, Inpatient and Detox).

Column 3 License Type:

Indicate what license each facility is registered as.

Column 4-Bed Capacity:
List the total number of beds per fiscal year that the facility is licensed to operate.

Column 5-Census Days:
List the total number of bed days occupied per fiscal year in each facility.

Column 6-Utilization Rate:
Column 5 automatically calculates the utilization rate in this column by dividing the census days by the bed capacity for each of the facilities. The provider should not enter any data in Column 5.

Column 7-Total Expenses:
The total expenses per residential/inpatient facility should be entered in Column 7. The total expenses in column 7 should tie to the total on Schedule 1 of Column 4, 5 and 8. Enter the information for Inpatient and ATU, this subtotal should equal the total in Column 4 of Schedule
1. Enter the information for any 24 hour Mental Health Residential Program, this subtotal should equal the total in Column 5 of Schedule 1.

Column 8- Cost per Day:
The total expenses from column 7 divided by Column 5 Census Days.

In this case, we can use allocation interchangeably with assignment. In order to remain consistent the use of the term allocation has been kept in use.

Chapter 5: Ability-To-Pay Guidelines

CHAPTER 5: ABILITY-TO-PAY GUIDELINES

The following Ability-to-Pay Guidelines are to be implemented by all centers and clinics.

It is important for each center and clinic to monitor its compliance with its own policies, these Ability-to-Pay Guidelines, Medicaid rules and regulations, Medicare rules and regulations and Champus rules and regulations.

1. Each Mental Health Center shall have a policy that establishes a reduced fee for non- Medicaid clients with Serious Emotional Disturbance/Serious Mental Illness, based on ability to pay, except Medicare/Medicaid clients, Medicaid fee-for-service clients or clients who are covered under specific third party payer contracts or agreements, including the Medicaid Capitation Program. The MHC policy may include a monthly or family rate.

2. Medicaid fee-for-service payments must be accepted in full for covered services. These clients can only be assessed for the co-pay mandated by the State Legislature.

3. Full fee for each modality covered by fee-for-service Medicaid must be equal to or greater than the unit cost for that service.

4. A discount for cash payments is at the discretion of the center or clinic.

5. Centers and clinics must have a write-off as well as a write-down policy. Write-offs are individual accounts receivable that the center deems uncollectible. Write-downs are the difference between full fee and the client's fee based on ability-to-pay. See Chapter 3 for more information about the appropriate accounting treatment of write-offs and write-downs.

6. A reasonable effort must be made by the center or clinic to collect its outstanding charges; collection agencies may be used.

Chapter 6: Instructions for the Supplemental Mental Health/Substance Use Disorders Cost Report

Managed Service Organizations and Sub-recipients

CHAPTER 6: INSTRUCTIONS FOR THE SUPPLEMENTAL MENTAL HEALTH/SUBSTANCE USE DISORDERS COST REPORT

INTRODUCTION

The purpose of this chapter is to provide guidance to organizations that have contracted with the State of Colorado, Office of Behavioral Health (OBH), for the delivery of treatment and intervention services and to the independent auditors of those organizations. Agencies contracting directly with the State of Colorado are referred to as Managed Service Organizations (MSOs). Agencies selling services to MSOs are referred to as Sub-recipients.

MSOs and Sub-recipients are expected to have adequate accounting and information systems in place to provide the data needed to meet the accounting and reporting requirements under the MSO and Sub-Recipient contracts. The internal control and quality assurance system must be adequate to provide for the accounting and reporting requirements. Auditors are expected to review the adequacy of the internal control.

The cost report and financial reports included in this chapter are to be followed to the maximum extent possible to provide uniformity and comparability.

INTERNAL CONTROLS AND LEVEL OF CARE SYSTEM

Internal Controls

a) Consideration of the Internal Control in a financial statement audit describes the elements of internal control and explains how an independent auditor should consider the internal control in planning and performing an audit. An entity's internal control consists of five elements: control environment, risk assessment, information and communication, monitoring, and control activities.

b) To plan the audit, the auditor obtains a sufficient understanding of each of the five elements by performing procedures to gain an understanding of the policies and procedures. The auditor should then conduct tests or other procedures to confirm the auditor's understanding of the system.

c) A fter obtaining an understanding of the elements of the internal control, the independent auditor assesses control risk for the assertions embodied in the account balance, transaction class, and disclosure components of the financial statements. The independent auditor uses the knowledge provided by the understanding of the internal control and the assessed level of control risk in determining the nature, timing and extent of substantive tests for financial statement assertions.

Contracts

1. ***Types of MSOs***
   a) A single stand-alone entity that has been awarded a MSO contract. This could be

a for-profit, not-for-profit or governmental organization – until July 2003, when governmental organizations are no longer eligible for MSO "designation".

b) A division or other type of subsidiary relationship with a larger organization. The larger organization could be a for-profit, not-for profit or governmental entity.

2. ***Contract Compensation***

MSOs are compensated for delivery of services. In order to fully earn the contracted compensation the MSO must provide 100% of the encounters specified in the contract. Payments on the contract are initially made at one- twelfth (1/12) of the contracted compensation and are adjusted in subsequent months if minimum services are not delivered. Additionally, line item compensation breakdowns are provided based on what I provided to the MSOs from OBH. (this is contract language – not guideline language)

Financial Statement Presentation -Required Reporting

1. ***Basis of Annual Financial Statement Presentation***

MSOs shall submit an annual audit report. Annual financial statement should conform to the current version of AICPA Audit Guides as appropriate. Sub-recipients receiving payments greater than $300,000 are required to be audited by contractual obligation with the MSO. Sub-recipients may also have additional reporting requirements, such as mental health reporting, RTC reporting, and OMB Circular A-133 reporting requirements.

Example reports for MSO organizations are presented in Exhibit E.
Example reports for Sub-recipients are presented in Exhibit F.

2. ***Supplementary Audit Schedules***

Sub-recipients of MSOs must report the costs associated with providing substance abuse services in the format presented in Exhibit F. These costs may be presented as part of the statement of operations, as a statement of functional expenses, or as supplemental information.

3. ***Agreed Upon Procedure Letter***

Each audit report should contain reports covering all financial statements and schedules presented. Supplemental information can be covered with a separate report or an additional paragraph included with the standard audit. The following is an example of the required additional paragraph to be included with the standard audit report:

"The audit referred to above was directed primarily toward formulating an opinion on the financial statements of Example Managed Service Organization taken as a whole. The supplementary information is presented for purposes of additional analysis as required by the State of Colorado, Department of Human Services and is not necessary for fair presentation of the financial position, results of operations, or cash flows for

Example Managed Service Organization. The supplementary information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is stated fairly in all material respects only when considered in conjunction with the financial statements taken as a whole."

3. ***Management Letter***
   In many engagements the auditor will identify certain weakness in or opportunities to strengthen a client's information system or organization structure. These recommendations are usually submitted with the annual audit and are commonly referred to as "management letters". DHS requires copies of the "management letter" along with a copy of the response by the MSO management to its Board outlining:

   1. The evaluation of the issues commented on by the auditor;

   2. Proposed courses of action to remedy the weakness or to modify the system or structure as suggested specifying both action steps and a timetable.

   Care should be exercised by the auditor to ensure that management letter comments representing findings to be reported under the requirements of OMB Circular A-133 are appropriately included in the applicable reports.

AICPA Guide for Health Care Organization

Applicability

This guide applies to health care organizations that are either (a) investor-owned businesses or (b) not-for-profit enterprises that have no ownership interest and are essentially self-sustaining from fees charged for goods and services, as defined in Financial Accounting Standards Board (FASB) Statement of Financial Accounting Concepts No.4, Objectives of Financial Reporting by Non-business Organizations, paragraph 8, or (c) governmental. This Guide applies to organizations whose principal operations consist of providing or agreeing to provide health care services and that derive all or almost all of their revenues from the sale of goods or services; it also applies to organizations whose primary activities are the planning, organizations, and oversight of such organizations, such as parent or holding companies of health care providers.

See Chapter 5 for a listing of health care organizations covered by the AICPA Guide for Health Care Organizations.

Chapter 5 also includes information on the applicability of the AICPA Audit Guide for Not-for-Profit Organizations.

Auditing Guidelines

The actual conduct of the financial audit is governed by generally accepted auditing standards and other authoritative pronouncements of the profession particularly the Audits of

Health Care Organizations, as well as the requirements contained elsewhere in this guide.

In addition to adhering to professional standards, the auditor should be familiar with the contents of this guide in conducting an audit of an entity subject to the requirements of the guide. The auditor should follow the appropriate audit guide in preparing the financial statements. The following is an example presentation following the not-for-profit audit guide.

In addition to completing financial statements (Exhibit A and E), the Mental Health providers who also provide SUD services and SUD only providers will complete a web-based Supplemental Cost Report form (Exhibit C) that requires detailed reporting of expenses and utilization. These schedules will capture the data necessary to calculate the base unit cost for each these providers, which will be used in the RVU pricing methodology. As described in Chapter 2, Standard 2, the provider will perform an expense classification process to separate expenditures into **functional cost centers**. This functional classification will be used to summarize items of costs (tied to the audited income statement) for each provider and allow for assignment or allocation of salaries and wages, staff travel costs, purchased services, and direct operating costs to the appropriate functional cost centers on the Supplementary Cost Report.

See Example 3 in Chapter 2 for the difference between direct costs that can be assigned to one cost center and direct costs that have to be allocated to multiple cost

Note: If you are a mental health only provider and do not provide substance use disorder services refer to Chapter 4 for the applicable cost report.

The functional cost centers defined on Schedule 1 of the Cost Report for Mental Health providers who provide SUD services and SUD only providers are as follows:

Column 1- Full Time EQV (FTEs):

A non duplicative count of all Full Time Equivalent employees based on an annual number of hours worked.

Column 2 - Indirect (Not Traceable to Direct Cost Center):

An administrative reporting unit is necessary to capture organizational-wide costs such as:

The Executive Director, CFO, Accounting, IT, and other administrative functions essential to the operation of the organization are indirect staff. Expenses that are not directly traceable to a cost center will be reported discretely in this cost center and allocated out to the direct service cost centers.

See the table in Chapter 2 for that suggests statistics that the provider should use to allocate costs.

The provider will allocate direct service costs that cannot be assigned to one cost center based on the allocation methodology outlined in Chapter 2, Standard 4. Personnel costs (salary, wages, benefits, etc.) for direct service employees must be allocated using time spent.

Once the provider has completed the functional expense classification to assign or allocate all direct costs to the different cost centers, the provider should follow the instructions to allocate these costs to the functional programs, establishing the total functional expense for each identified program on the schedule.

Column 3 - Encounter-based Mental Health Services with RVU Weights:

For costs related to the provision of outpatient mental health services which generate encounters with clearly defined Mental Health CPT/HCPCS billing codes and have established RVU weights assigned to them.

Column 4 - Encounter-based Mental Health Inpatient Hospital Claims without RVU Weights:

For costs related to the provision of mental health inpatient services or in an Acute Treatment Unit (ATU) which generate encounters (irrespective of billing code), but do not have established RVU weights assigned to the codes.

> Note: The cost of providing encounter-based services with RVU weights such as professional services in an inpatient setting (therapy, medication management, evaluations, etc), are to be classified under the **Encounter-based Mental Health Services with RVU Weights** cost center, noted in A. above.

Column 5 Encounter-based Residential Services without RVU Weights:

For costs related to the provision of mental health residential services in a 24 HR Supervised Residential program which generate encounters, but do not have established RVU weights assigned to them.

These residential services are provided in Short-Term Residential Treatment Facilities, Long-Term Residential Treatment Facilities, or Acute Treatment Facilities.

> Note: The cost of providing encounter-based services with RVU weights such as professional services in a residential setting (therapy, medications management, evaluations, etc) are to be classified under **the Encounter-based Mental Health Services with RVU Weights** cost center, noted in A. above.

Column 6 - Encounter-based Other Mental Health Services without RVU weights and Non-encounter based Mental Health Costs (OTHER):

For costs related to other mental health services that do not have established RVU weights assigned to them. Costs associated with any of the following services that generate encounters, but do not have RVU weights: OBH Early Childhood direct services, Other Capacity funded programs, pharmacy encounters, emergency encounters (w/o RVU weights) and lab encounters. For costs related to other mental health programs that do not generate encounters. Costs associated with retail pharmacy or contracted lab services, psychiatric medications and other services that are funded wholly by outside grantors, and other non-encountered services such as housing services.)

Column 7 - Encounter-based Substance Abuse with RVU Weights:

For costs related to the provision of outpatient substance abuse services which generate encounters with clearly defined CPT/HCPCS billing codes and have established RVU weights assigned to them.

Column 8 - Encounter-based Substance Abuse Residential services without RVU Weights:

For costs related to the provision of substance abuse residential services in either a Detox facility or other 24 HR Supervised Residential program which generate encounters or a per diem, but do not have established RVU weights assigned to them.

Column 9- Encounter-based Substance Abuse without RVU Weights and Non-Encounter Based Substance Abuse Costs (Other):

For costs related to encounter-based Substance Abuse services that generate encounters, but do not have established RVU weights assigned to them. Costs will typically be related to capacity based Substance Abuse services such as monitoring services (UA/Breathalyzers) or DUI education classes. For costs related to other substance abuse related/fully funded programs that do not generate encounters. Costs associated with services that are funded wholly by outside grantors, and other non-encountered substance abuse services.

Column 10 - Non-encounter based BHO Administrative Costs (Mental Health):

For costs related to the administration of the Medicaid Capitation Program that have been subcontracted to the CMHC outside of the existing contract requirements from the Behavioral Health Organization. The CMHC will be reimbursed for the cost of these activities by the BHO as part of the administrative component of the capitation rate to the BHO. An agreement will exist between the BHO and the CMHC to perform these services necessary for the administration of the BHO. Costs related to any type of face-to-face service **should not** be reported in this cost center.

Column 11 - Non-encounter based Administrative Costs (MSO):

For costs related to the administration of the Substance Abuse Program that have been subcontracted to the MSOs outside of the existing contract requirements from the Behavioral Health Organization. The SUD providers will be reimbursed for the cost of these activities by the MSOs as part of the administrative component of the capitation rate to the MSO. An agreement will exist between the MSO and the SUD Providers to perform these services necessary for the administration of the MSO. Costs related to any type of face-to-face service **should not** be reported in this cost center.

Column 12 - Unallowable costs:

For all costs that are identified as unallowable for the calculation of the Base RVU cost. These costs are detailed in Chapter 2.

Providers have the option to either complete Schedule 1 or Schedule 1A in order to report their trial balance of expenses. Schedule 1A automatically fills column 1 in the event a provider complete schedule 1A.

SCHEDULE 1 – TRIAL BALANCE OF EXPENSES (by Natural Classification)

Schedule 1 records the trial balance for the provider at the end of the reporting period. The costs reported on Schedule 1 must come directly from the SUD provider's trial balance, which includes all activities conducted by the reporting entity. **The standard preprinted line numbers and cost center descriptions cannot be changed or modified by the provider.**

Line 1 – Total Direct Program Staff FTE and Salaries:

Line 1, column 1 should be used to record all direct program staff full-time equivalents (FTEs). An FTE will be based on annual number of hours worked/2080 hrs.

Line 1, column 3-12, should be used to record the salaries, wages, and other non-fringe compensation for the direct care program staff incurred by each functional cost center. This line includes all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" as defined in Chapter 3.

Line 2 – Total Administrative Staff FTE and Salaries:

Line 2, column 1 should be used to enter the FTE's and salaries for the Administrative staff who are not directly assignable to a clinical program or facility. An FTE will be based on annual number of hours worked/2080 hrs.

Line 2, column 2 should be used to record the salary, wages and other non-fringe compensation for those individuals reported in column 1. This line includes all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" as defined in Chapter 3.

NOTE 1: The total FTE for Direct Program Staff + Administrative Staff = the total Agency FTE as of June 30, 2013.

NOTE 2: Acceptable methods for allocating salaries for lines 1 and 2 to different functional expense classifications include either:

- Journal entries in accounting system; or
- Service activity logs; or
- Time study.

Line 3 – Total Personnel

Line 3 automatically calculates the Total Personnel columns 3-10; there is no data entry on this line.

Lines 4 – 10 – Natural Classification of Expenses:

Lines 4 – 10, columns 2-11 will contain all non-compensation expenses by natural classification.

- Provider should report costs which cannot be allocated directly to a direct service cost center (Indirect expenses only) in column 2 by the appropriate line definition. (See Chapter 2).
- For columns10 & 11– Non-Encounter Based BHO Administrative Costs and

Unallowable Costs, these costs as defined in Chapter 2 are accumulated by natural classification in the respective columns (See Chapter 2).

- For columns 3-9, the provider should report all costs that are charged or allocated directly to the direct service cost centers that have not been recorded in column 2, 10 or 11. The costs should be classified by the appropriate line definition (See item K. above.).

  NOTE: The Natural Classification definitions (lines 1-10) and specific expense item roll ups are detailed in Chapter 2.

Line 11, columns 2-11– Total Direct Expenses:

Line 11, columns 2-11 will automatically sum. No data entry required.

Line 12, column 2 – Allocation of Indirect Cost to Functional Programs:

Line 12, column 2 – is the amount of indirect cost to be allocated to the functional programs to obtain full functional program cost. It is the negative of the total expenses for column 2 located on line 11.

Cost allocation for line 12, across columns 3-11 must be based on a sound methodology for allocation. This line will total to $0 in column 12, as it is an allocation to offset the amount in line 12, column 2.

Documentation of the allocation methodology is required. The provider must select at the bottom of Schedule 1, which allocation method is being used to allocate the indirect costs across the functional programs. *If the Other allocation is used, an explanation of the allocation methodology is required.*

Line 13 – Total Cost:

Line 13 automatically computes the total functional program cost in each column by adding Line 11, Total Direct Expense and Line 12, Indirect Cost Allocation.

NOTE: Line 1 and Lines 3 – 11 (across columns 2-11), as summed in column 12 (**Total Cost**) should tie by the natural expense classification line item to the audited expenses shown on the CMHC **Statement of Operations.** *Column 12 is an auto sum column (cross totaling columns 2-11), no data entry required.*

Line 14 – Unduplicated Client Count:

Unduplicated Client Count line provides the denominator by program to calculate the average cost per client.

- Providers are to report the total number of clients served by program. Client counts may be duplicated by program.

Line 15 – Cost per Unduplicated Client

Average Cost per Client is an automatically calculated field (Total Cost divided by Unduplicated Client Count)

SCHEDULE 1A – TRIAL BALANCE OF EXPENSES (by Natural Classification)

Schedule 1A records the trial balance for the SUD provider at the end of the reporting period. The costs reported on Schedule 1A must come directly from the provider's trial balance, which includes all activities conducted by the reporting entity. **The standard preprinted line numbers and cost center descriptions cannot be changed or modified by the provider.**

Column 1- Full Time EQV (FTEs): A non duplicative count of all Full Time Equivalent employees based on an annual number of hours worked.

Column 2 - Indirect (Not Traceable to Direct Cost Center):

An administrative reporting unit is necessary to capture organizational-wide costs such as:

The Executive Director, CFO, Accounting, IT, and other administrative functions essential to the operation of the organization are indirect staff. Expenses that are not directly traceable to a cost center will be reported discretely in this cost center and allocated out to the direct service cost centers.

The provider will allocate direct service costs that cannot be assigned to one cost center based on the allocation methodology outlined in Chapter 2, Standard 4. Personnel costs (salary, wages, benefits, etc.) for direct service employees must be allocated using time spent.

Once the provider has completed the functional expense classification to assign or allocate all direct costs to the different cost centers, the provider should follow the instructions to allocate these costs to the functional programs, establishing the total functional expense for each identified program on the schedule.

Column 3 –Prevention:

Prevention Service are defined as:

Prevention services are targeted towards individuals before they develop an alcohol and/or drug use disorder. Prevention programs promote constructive lifestyles and norms that discourage alcohol and/or drug usage. Prevention services utilize a variety of strategies, including screening and outreach services that identify at-risk populations, proactive efforts to educate and empower individuals to choose and maintain healthy behaviors, and lifestyle choices that promote positive behavioral health choices.

Column 4 –Screening and Intervention:

Screening and Intervention Services are defined as:

Screening can consist of two separate activities, depending upon its purpose.

When used as a part of treatment, screening services are often performed through

specimen collection to test for the presence of alcohol and/or drugs. Screening is also used to identify individuals whose substance use may put them at increased risk for health problems or other substance use related problems. Intervention services provide advice or counseling to individuals with minor or risky substance use disorders, and are also used to encourage individuals with a serious dependence problem to seek or accept a more intensive treatment regimen.

Column 5 – Support Services:
Support Services are defined as:

Support services provide choices, assistance, and opportunities to individuals with substance use disorders. Services that target an individual's recovery will promote the self-management of psychiatric symptoms, prevent relapses, provide treatment choices, offer mutual support, offer enrichment, and promote the protection of one's rights. Support services will provide social supports and a lifeline for individuals having difficulties stemming from substance abuse disorders. Recovery services are generally provided by behavioral health peers or family members in addition to licensed counselors.

Column 6 –Social and Ambulatory Detoxification- Treatment:
Social and Ambulatory Detoxification Services are defined as:

Social Ambulatory Detoxification services are rendered to clients whose intoxication or withdrawal signs and / or symptoms are severe enough to require a 24-hour structured program. These services are not provided to clients that require hospitalization for their intoxication or withdrawal symptoms. Medicaid reimbursed services are provided on a residential basis by a facility that is licensed by the Colorado Department of Human Services (CDHS), Office of Behavioral Health (OBH) based on the American Society of Addiction Medicine (ASAM) criteria.

Column 7 –Case Management Assessment and Treatment-Outpatient:
Case Management, Assessment and Treatment-Outpatient Services are defined as:

The assessment process helps to determine the nature and extent of a person's difficulties with substances. Assessment instruments collect and clinicians evaluate information about a client in order to develop a profile that is used for service planning and referrals to treatment. Treatment services utilize a variety of methods to treat mental, behavioral, and substance use disorders. The goal is to alleviate emotional disturbances and reverse or change maladaptive patterns of behavior in order to encourage a client's personal growth and development. Case Management services are provided through a licensed substance use disorder

treatment program. These services help clients gain access to necessary medical, social, educational, and other necessary services. Services may include any of the following: assessment of an eligible individual; development of a specific care plan; referral to services; and monitoring and follow-up activities, and benefits acquisition and maintenance

Column 8 - Social and Ambulatory Detoxification – Room and Board:
Social and Ambulatory Detoxification Room and Board Service is defined as:

The Room and Board costs associated with providing social ambulatory detoxification services as rendered to clients whose intoxication or withdrawal signs and / or symptoms are severe enough to require a 24-hour structured program. These costs are not to be duplicated with the Social Ambulatory Detoxification Treatment Services but instead are the direct Room and Board Services.

Column 9- Treatment – Residential:
Treatment – Residential Services are defined as:

Treatment Residential Services are defined as the costs associated with all direct residential costs associated with treatment services. Treatment services utilize a variety of methods to treat mental, behavioral, and substance use disorders. The goal is to alleviate emotional disturbances and reverse or change maladaptive patterns of behavior in order to encourage a client's personal growth and development.

Column 10 – Room and Board:
Room and Board Services are defined as:

Room and Board Services are provided to patients residing in a facility. Patients must reside in the facility for at least 24 hours while they are provided with lodging and meals.

Column 11 – Unallowable Costs:
Unallowable Costs are defined as:

For all costs that are identified as unallowable for the calculation of the Base RVU cost. These costs are detailed in Chapter 2.

Providers have the option to either complete Schedule 1 or Schedule 1A in order to report SUD for their trial balance of expenses. Schedule 1A automatically fills in Schedule 1 SUD columns in the event a provider completes schedule 1A.

Line 1 – Total Direct Program Staff FTE and Salaries:

Line 1, column 1 should be used to record all direct program staff full-time equivalents (FTEs). An FTE will be based on annual number of hours worked/2080 hrs.

Line 1, column 3-13, should be used to record the salaries, wages, and other non-fringe compensation for the direct program staff incurred by each functional cost center. This line includes all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" as defined in Chapter 3.

Line 2 – Total Administrative Staff FTE and Salaries:

Line 2, column 1 should be used to enter the FTE's and salaries for the Administrative staff who are not directly assignable to a clinical program or facility. An FTE will be based on annual number of hours worked/2080 hrs.

Line 3 – Total Personnel

Line 3 automatically calculates the Total Personnel columns 3-10; there is no data entry on this line.

Lines 4 – 10 – Natural Classification of Expenses:

Lines 4 – 10, columns 3-11 will contain all non-compensation expenses by natural classification.

- Provider should report costs which cannot be allocated directly to a direct service cost center (Indirect expenses only) in column 2 by the appropriate line definition. (See Chapter 2).

For columns 3-11 the provider should report all costs that are charged or allocated directly to the direct service cost centers. The costs should be classified by the appropriate line definition.

NOTE: The Natural Classification definitions (lines 1-10) and specific expense item roll ups are detailed in Chapter 2.

Line 11, columns 3-13– Total Direct Expenses:

Line 11, columns 3-13 will automatically sum. No data entry required.

Line 12, column 2 – Allocation of Indirect Cost to Functional Programs:

Line 12, columns 3-13 will automatically sum. No data entry required.

Line 13 – Total Cost:

Line 13, columns 3-13 will automatically sum. No data entry required.

NOTE: Line 1 and Lines 3 – 11 (across columns 3-12), as summed in column 13

(**Total Cost**) should tie by the natural expense classification line item to the audited expenses shown on the SUD provides **Statement of Operations.** *Column 13 is an auto sum column (cross totaling columns 2-12), no data entry required.*

Line 14 – Unduplicated Client Count:
Unduplicated Client Count line provides the denominator by program to calculate the average cost per client.

- Providers are to report the total number of clients served by program. Client counts may be duplicated by program.

Line 15 – Cost per Unduplicated Client
Average Cost per Client is an automatically calculated field (Total Cost divided by Unduplicated Client Count)

SCHEDULE 2A – SUPPLEMENTAL SCHEDULE FOR COLUMN 6

Schedule 2A Section I please list each individual expense that is greater than or equal to $50,000 that was included in Column 6 of Schedule 1. Section II please put the total of all expenses that were less than $50,000 that were included in Column 6 on Schedule 1.

SCHEDULE 2B – SUPPLEMENTAL SCHEDULE FOR COLUMN 9

Schedule 2B Section I please list each individual expense that is greater than or equal to $50,000 that was included in Column 9 of Schedule 1. Section II please put the total of all expenses that were less than $50,000 that were included in Column 9 on Schedule 1.

Schedule 3 and 3A both contain the substance abuse services without an RVU weight. Providers need to only complete utilization data on a single schedule for the non RVU weighted services.

SCHEDULE 3 – UTILIZATION (ENCOUNTER-BASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES WITH NON-FACILITY RVU WEIGHTS)

Schedule 3 collects utilization data for *Encounter-based Mental Health and Substance Abuse Services with RVU weights*, as defined above, for all services provided in a Non-Facility setting. All services provided outside of the Community Mental Health Center or SUD provider should be considered non- facility place of service, and will use non-facility RVU weight. Schedule 3 also collects utilization data for non RVU weighted services.

Units of service reported on Schedule 3 should only be related to the costs reported on Schedule 1, from Column 3 and Column 7 Encounter-based Mental Health and Substance Abuse Services with RVU weights.

In order to complete schedules 3, the provider must track each encounter or unit of service by the following data elements:

1. Direct Care Provider Information (Employee I.D., Education level, etc.)

2. Client Information
3. Service Information
    a. Primary Diagnosis code
    b. Service/revenue code
    c. POS code
    d. Date of Service
    e. Number of Units

From the service encounter data, providers will track service delivery by utilization over the course of the entire fiscal year for input into Schedules 3 and 3A. The following instructions describe how Schedule 3 organizes the utilization data.

Column 1 – Total Units for Mental Health
Providers should report all *mental health encounter able units of service with an RVU weight* provided in a Non-Facility setting by the CPT/HCPCS codes listed in lines 1-232. Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as defined in this column. Line 233 automatically calculates the total units; the provider should not enter any data in this line.

Column 2- Total Relative Value Units Mental Health
All rows in this column are calculated automatically. The calculation is the Column heading "Non-facility RVU Weight" X the number of units in Column 1. (i.e. Line 1 = 4.43 (RVU weight) X units from line 1 Column 1).

Column 3 – Total Units for Substance Abuse
Providers should report all *substance abuse encounter able units of service with an RVU weight* provided in a Non-Facility according to the CPT/HCPCS codes listed in lines 1-232 Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 233 automatically calculates the total units; the provider should not enter any data in this line.

Column 4 – Total Relative Value Units Substance Abuse
All rows in this column are calculated automatically. The calculation is the Column heading "Non-facility RVU Weight" X the number of units in Column 1. (i.e. Line 1 = 4.43(RVU weight) X units from line 1 Column 3).

SCHEDULE 3A – UTILIZATION (ENCOUNTER-BASED MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES WITH FACILITY RVU WEIGHTS)

Schedule 3A collects utilization data for *Encounter-based Mental Health and Substance Abuse Services with RVU weights*, as defined above, for all services provided in a Facility setting. All services provided in a Community Mental Health Center or SUD provider should be considered facility place of service, and will use facility RVU weight. Schedule 3A also collects utilization data for non RVU weighted services.

Units of service reported on Schedule 3A should only be related to the costs reported

on Schedule 1, Column 3 and column 7 Encounter-based Mental Health and Substance Abuse Services with RVU weights.

In order to complete schedules 3, the provider must track each encounter or unit of service by the following data elements. These units must be recorded for entry into schedule 3.

1. Direct Care Provider Information (Employee I.D., Education level, etc.)
2. Client Information
3. Service Information
    a. Primary Diagnosis code
    b. Service/revenue code
    c. POS code
    d. Date of Service
    e. Number of Units

From the service encounter database, providers will track utilization over the course of a year for input into Schedules 3 and 3A. The following instructions describe how Schedule 3A organizes the utilization data.

Column 1 – Total Units for Mental Health

Providers should report all *mental health encounter able units of service with an RVU weight* provided in a Facility setting by the CPT/HCPCS codes listed in lines 1-232. Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as defined in this column. Line 233 automatically calculates the total units; the provider should not enter any data in this line.

Column 2- Total Relative Value Units Mental Health

All rows in this column are calculated automatically. The calculation is the Column heading "Facility RVU Weight" X the number of units in Column 1. (i.e. Line 1 = 3.44 (RVU weight) X units from line 1 Column 1).

Column 3 – Total Units for Substance Abuse

Providers should report all *substance abuse encounter able units of service with an RVU weight* provided in a Facility according to the CPT/HCPCS codes listed in lines 1-232 Service definition for the CPT/HCPCS codes are in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 233automatically calculates the total units; the provider should not enter any data in this line.

Column 4 – Total Relative Value Units Substance Abuse

All rows in this column are calculated automatically. The calculation is the Column heading "Facility RVU Weight" X the number of units in Column 3. (i.e. Line 1 = 3.44 (RVU weight) X units from line 1 Column 3).

SCHEDULE 4 BASE UNIT COST CALCULATION

Schedule 4 automatically calculates the provider-specific base unit cost for mental health and substance abuse. The provider should not enter any data on Schedule 4.

At the top of Schedule 4, the Total Allowable Cost for Encounter-Based Mental Health Services is pulled in from Schedule 1, Column 3, Line 13. Next, the Total Relative Value Units for mental health are pulled in from Schedule 3, Column 2, Line 233 and Schedule 3A, Column 2, Line 233. Then, the Base Unit Cost for Mental Health is automatically calculated by dividing the Total Allowable Cost for Encounter-Based Mental Health Services by the Total Relative Value Units for Mental Health.

Also at the top of Schedule 4, the Total Allowable Cost for Encounter-Based Substance Abuse Services is pulled in from Schedule 1, Column 7, Line 13. In addition the Total Relative Value Units for Substance Abuse are pulled in from Schedule 3, Column 4, Line 233 and Schedule 3A, Column 4, Line 233. Likewise the Base Unit Cost for Substance Abuse is automatically calculated by dividing the Total Allowable Cost for Encounter-Based Substance Abuse Services by the Total Relative Value Units for Substance Abuse.

Column 1 – Mental Health Cost per Non-Facility Unit of Service

Column 1 automatically calculates the cost of providing a unit of service in a Non-Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Non-Facility RVU weight.

Column 2 – Mental Health Cost per Facility Unit of Service

Column 2 automatically calculates the cost of providing a unit of service in a Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Facility RVU weight.

Column 3 – Substance Abuse Cost per Non-Facility Unit of Service

Column 3 automatically calculates the cost of providing a unit of service in a Non-Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Non-Facility RVU weight.

Column 4 – Substance Abuse Cost per Facility Unit of Service

Column 4 automatically calculates the cost of providing a unit of service in a Facility setting for each of the CPT/HCPCS procedures by multiplying the base unit cost by the Facility RVU weight.

SCHEDULE 4A-BASE UNIT COST CALCULATION/NON RVU CODES

Schedule 4A calculates the provider-specific base unit cost for non-RVU mental health and substance abuse. For column 3 the Units are pulled from Schedules 3 and 3A accordingly and there is no manual data entry required. The provider should not enter any data on Schedule 4A.

Units entered in column 3 are automatically calculated for each functional cost center in the Total Units line. The Total Costs line for each functional cost center is pulled from the corresponding cost center in Schedule 1A line 13, Total Cost. Next, the Total Cost Per Unit line is automatically calculated by dividing the Total Costs (from schedule 1A) by the Total Units.

In lieu of Schedule 1A, a Cost Per Unit can still be determined at the bottom of Schedule 4A in the Cost Per Unit (In Lieu of Schedule 1A) box. The Total Units line from each functional cost center box is automatically calculated in the Total Units line. The Total Substance Abuse Cost (from Schedule 1) is pulled from Schedule 1 and calculated from line 20 column J for Encounter-Based Substance Abuse Residential without RVU weights and column K for Encounter-Based Substance Abuse without RVU weights and Non-Encounter-Based Substance Abuse Costs (Other). Next, the Total Cost Per Unit line is automatically calculated by dividing the Total Substance Abuse Cost (from Schedule 1) by Total Units.

SCHEDULE 5-RESIDENTIAL/INPATIENT SERVICES DETAIL

Schedule 5 requires providers to report information about the residential/inpatient facilities in greater detail. The provider should list only as many residential/inpatient facilities as it operates.

Column 1-Name of Facility:

List the names of all the residential/inpatient facilities that the CMHC or SUD provider operates. List one facility per line and be as specific as possible.

Column 2-Type of Facility:

Specify the type of facility (Residential, ATU, Inpatient and detox)

Column 3 License Type:

Indicate what license each facility is registered as.

Column 4-Bed Capacity:

List the total number of beds per fiscal year that the facility is licensed to operate.

Column 5-Census Days:

List the total number of bed days occupied per fiscal year in each facility.

Column 6-Utilization Rate:

Column 5 automatically calculates the utilization rate in this column by dividing the census days by the bed capacity for each of the facilities. The provider should not enter any data in Column 5.

Column 7-Total Expenses:

The total expenses per residential/inpatient facility should be entered in Column 7. The total expenses in column 7 should tie to the total on Schedule 1 of Column 4, 5 and 8. Enter the information for Inpatient and ATU, this subtotal should equal the total in Column 4 of Schedule

1. Enter the information for any 24 hour Mental Health Residential Program, this subtotal should equal the total in Column 5 of Schedule 1. Enter the information for any 24 hour Substance Abuse Residential Program, this subtotal should equal the

total in Column 8 of Schedule 1.

Column 8- Cost per Day:
The total expenses from column 7 divided by Column 5 Census Days.

EXPORT FEATURE
After completing the web-based Cost Report for SUD services, Mental Health providers have the option of exporting the cost report data into an Excel document so the mental health cost data can be submitted through the proper channels to HCPF. Instructions for exporting the data will be identified within the instructions on the web-based system.

In these Guidelines, we use the term "allocation" interchangeably with "assignment." To remain consistent within these Guidelines, the term "allocation" is used throughout.

Chapter 7: Management of Client Funds

CHAPTER 7: MANAGEMENT OF CLIENT FUNDS

I Beneficiaries Receiving Services in Long Term Care Facilities

A. INTRODUCTION

Individuals receiving services often need assistance managing their funds. The requirements that providers of Long Term Care Facilities need to meet in providing money management assistance to clients are identified in this chapter. The following requirements were developed from information contained in CRS 26-4-504 and CFR 42 483.10 titled, Resident Rights In Long Term Care Facilities.

B. CLIENT RIGHTS AND FACILITY'S RESPONSIBILITIES

1. The client (his or her legal guardian) has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

2. Upon the written authorization of a client, the facility must hold, safeguard, manage, and account for all of the personal funds of the client deposited with the facility.

3. At all times, the principal and all income derived from said principal in the clients' accounts shall remain the property of the participating clients.

4. The facility must record and periodically update the address and phone number of the client's legal representative or interested family member.

5. The facility must establish and maintain an accounting system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each client's funds entrusted to the facility on the client's behalf. The system must include individual account ledgers. These ledgers must:

   a. identify all deposits
   b. identify all withdrawals
   c. reference supporting documentation for all transactions

6 The facilities' personal funds system must preclude any commingling of client funds with facility funds or with the funds of any person other than another client.

7. Deposit of clients' Funds:

   a. The facility must deposit clients' personal funds in an interest-bearing checking and/or savings accounts (pooled account) that are separate from any of the facility's operating accounts and that credits all interest earned on these funds to that account.
   b. An imprest petty cash fund may be established from this account to more efficiently service the clients' needs.
   c. All bank accounts established for the maintenance of residents; personal funds shall be clearly designated as a "client trust fund account".
   d. All interest earned on client funds entrusted to the facility on the client's behalf must

be allocated and distributed to the clients based on the average daily balance each client has on deposit with the facility. The client shall have the right to waiver participation in the allocation of interest for the month of discharge, withdraw his or her account balance and receive an accounting for these funds at the date of discharge rather than wait for an interest allocation to be credited to the client's account following the facility's accounting close for the month of discharge.

8. The individual client's financial record must be available through at least quarterly statements and on request by the client or his or her legal representative.

9. Upon the death of a client with personal funds deposited with the facility, the facility must convey within 30 days the client's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the client's estate.

10. In all instances of discharge, the refund of the client's account balance shall be made within
15 days following the close of the facility's accounting cycle for the month of discharge or
30 days following the date of discharge whichever occurs first.

11. The facility or its designated trustee shall post a surety bond in an amount to assure the security of all personal needs funds deposited in the client personal needs trust fund or shall otherwise demonstrate to the satisfaction of the Colorado Office of Behavioral Health (OBH) that the security of clients' personal needs funds is assured.

12. All client personal needs trust funds shall be subject to audit by OBH. A record of a client's personal needs trust funds shall be kept by the facility for a period of three years from the date of the client's discharge from the facility or until such records have been audited by CDHS, whichever occurs later.

13. Limitation on charges to personal funds:

a. No charge for handling personal needs trust funds shall be made to the client. Such charges should be included as part of the audited cost used to determine per diem resident maintenance charges.

b. The facility shall not impose a charge against the personal funds of a resident for any item or service for which payment is made under the facility's per diem resident maintenance charge. Per diem maintenance charges include but are not limited to:

(1) Dietary services as required.
(2) Room/Bed Maintenance services as required. (3) Training or education as required.
(4) An activities program as required.
(5) Routine personal hygiene items and services as required to meet the needs of the residents including but not limited to:

(a) Hair hygiene supplies, comb, brush, etc. (b) Razor and shaving cream

(c) Toothbrush, toothpaste, dental floss. (d) Mouthwash and deodorant.
(e) Towels, washcloths and tissues.
(f) Bath soap, disinfecting soaps including specialized cleansing agents when indicated to treat special skin problems or to fight and control infections.
(g) Basic personal laundry and bathing.
(h) Sanitary napkins and related supplies.

c. The facility may not charge a client (or his or her representative) for any item or service not requested by the client.

14. Items and services the facility may charge to client's funds providing the following conditions are meet:

a. The item or service is requested by the client.
b. The facility informs the client that there will be a charge and what the charge will be.
c. Payment for the item or service is not provided within the per diem maintenance charges and alternative funding is not available from Medicaid, Medicare or other sources of public or private assistance.

Items and services chargeable to the client, provided the above listed conditions are met include:

a. Telephone
b. Television/radio for personal use.
c. Personal comfort items including tobacco products, notion and novelties, and confections.
d. Cosmetic and grooming items in excess of those included within the per diem maintenance charge and alternative sources of assistance.
e. Personal clothing.
f. Personal reading matter.
g. Gifts purchased on behalf of a resident. h. Flowers and plants.
i. Social events and entertainment offered outside the scope of the activities program included within the per diem maintenance charge.
j. Occasional specially prepared or alternative food requested in addition to or in place of the food generally prepared by the facility and paid for within the facility's per diem maintenance charge.

15. Amounts owed to former clients may be lawfully cleared from the accounts in the annual report required under the Unclaimed Property Act, CRS 38-13-110. A guide and reporting forms for the Unclaimed Property Program may be obtained from the Colorado State Treasurer, phone 303-894-2443.

II. Beneficiaries Receiving Services in Community Based Mental Health Centers -- Representative Payees

A. INTRODUCTION

Part I. of Chapter 7 is designed to accommodate those beneficiaries who are patients of long term care facilities, i.e., nursing homes and other institutional care. Part II. is designed to accommodate those beneficiaries who are clients receiving services through community-based mental health centers or clinics, and the community mental health center or clinic is the representative payee. Much of Part II is based on information found in the Social Security Administration Publication No. 17-013, ICN 443170. Part II was reviewed by the Public Affairs Specialist of the Denver Social Security Office. When appropriate, State policy or suggestions are indicated.

A beneficiary is a person who receives Social Security benefits. In general, a person who has worked and had money withheld from earnings, can get a Social Security benefit if he or she becomes disabled. The amount that someone receives depends on the age at which he or she retires or becomes disabled, how long he or she worked, and the amount of earnings.

A recipient is a person who receives Supplemental Security Income (SSI) payments. When a person is 65 or older, blind or disabled and he or she has not worked enough to qualify for Social Security, he or she may get SSI payments. In order to qualify, he or she cannot have over $2,000 ($3,000 for a couple) in resources. The person assuming the responsibility of payee should be aware of the restrictions.

Social Security and SSI are two different programs that are both administered by SSA. The agency should have staff that can assist in the acquisition of benefits, and be aware of their limitations. It is important to be aware of which type of payment the beneficiary/recipient is receiving and what events/changes need to be reported to SSA. For the purposes of Part II., the title beneficiary and recipient are jointly referred to as “beneficiary”.

B. ACCOUNTING AND AUDITING

1. The role of the independent auditor is to assure that the funds are properly segregated and correctly reported in the financial statements. They should also review and test the appropriateness of the internal controls established by the agency.

2. The role of the state office that has oversight of the agency is to review the system established by the agency on a periodic base.

3. The role of the agency acting as representative payee is to assure that the funds are spent according to the rules and regulations established by the Social Security Administration. The agency is also required by contract to comply with the DHS Accounting and Auditing Guidelines, which has some additional standards. The agency may wish to include some documentation in the clinical chart that the agency is the client’s representative payee.

4. Financial Statement Reporting

a) Current Asset -- Separate Cash/Bank Account and General Ledger
Account b) Current Liability -- Separate General Ledger Account
c) Independent Auditors to review appropriate presentation and controls over cash accounts

B. USE OF BENEFITS -- AS DEFINED BY SOCIAL SECURITY ADMINISTRATION

1. Per SSA, the first use of the funds is to make sure the beneficiary's day-to-day needs for shelter and food are met. Current and basic needs also include clothing and medical care. Thus, a definition of shelter includes:

a) Independent living (room)
b) Group homes (room and board)
c) Supervised residential facilities (room, board, and supervision)

2. Per SSA, benefits may be used to pay for medical needs and dental care that are not provided by Medicare, Medicaid or other sources. Therefore, the representative payee agency may be reimbursed for the cost of services provided to the beneficiary.

3. Benefits may also be used for the beneficiary's personal needs only if their basic immediate needs or foreseeable future needs are met. Any money left after meeting basic needs should be saved for foreseeable future needs. Only if there is money left after meeting basic needs or saved for future needs, should you consider paying for personal items.

4. Debts incurred by client. As payee, you are not liable for debt incurred by your client. A client's basic needs must be met as a priority (i.e. credit card debt, or paying past due cable bill so they can resume service IS NOT a basic need). SSA or SSI benefits can only be used to pay debt, if their current basic needs are met.

- If they owe back rent, or they will lose their housing, this is a basic need, and you do not need SSA permission to pay this type of debt.
- The agency must use appropriate judgment when large retroactive benefit checks are received.
- If the organization acting as a payee is also a creditor of the client, i.e., a landlord or an institution, the organization must get SSA's approval before reimbursement of debt owed to the organization directly is paid.

D. ACCOUNTING ISSUES

1. Bank Account
a) Separation of Funds: Each beneficiary's fund transactions and balance must be accounted for separately and on a regular basis. MHS suggests monthly accounting; quarterly is the accounting period that the State considers as a minimum standard.
    - The agency may wish to use the direct deposit methodology for the receipt of the funds. The agency must be able to trace the actual deposits by the

individual beneficiary.

- The agency should have written policies and procedures that deal with rules of confidentiality and privacy. In general, there may be financial discussions with external agencies, but there are specific limitations on the sharing of clinically based information.
- The client has a right to receive a status report upon request. The request should be complied within five to ten working days, or the agency must provide the beneficiary with a reasonable accommodation of the request.
- The agency may restrict the number of requests during a month, as defined in the agency's written policies and procedures.

b) Collective Account: A single checking or savings account, called a "collective account", may be used if the agency has a methodology in place to accommodate reporting each beneficiary's fund transactions and balance separately.

- Example: Separate accounting system in which each beneficiary has his or her own account and these separate accounts roll-up to a summary page.
- Example: Separate spreadsheet file in which each client has his or her own sheet or page and these pages roll-up to a summary page.
- Example: Separate software package that accommodates separate accounting and a roll-up of summary information

c) Administrative Funds: The agency may choose to contribute a small amount for start-up funds or to accommodate timing differences. These administrative funds are to be accounted for separately and may be treated as an administrative account. The agency should contact their local Social Security office for additional guidelines.

- Example: Benefits are confirmed and forthcoming, but the beneficiary's bills need to be paid before the actual check is received by the agency.
- Example: The beneficiary is moving from one agency's service area to another service area. The rent is due, but the check has not yet followed the beneficiary.

d) Negative Balances: The beneficiaries' individual accounts should not be in a negative balance at the end of the accounting period.

- The agency could allow a negative balance if the agency chooses to subsidize the negative balance. This could be done through the small amount set-aside as start- up funds or through a separate contribution or payment of the expense incurred. The agency must make certain that the administrative account is greater than or equal to the negative balances in the beneficiaries' individual accounts.
- Other beneficiaries' funds must not be used to subsidize another beneficiary's individual fund.

2. Interest

a) SSA prefers that the bank account be an interest-paying account that is insured under either federal or state law. It may be difficult for an agency to find an interest-paying account, or for the interest to be greater than the cost of the account.

- Earned Interest: Banking arrangements are typically handled in one of two ways. The first is that each transaction (deposit, disbursement) will be charged a minimum fee, by the bank, and deducted from the account. This scenario will most likely provide interest to be credited to the account. The second is to have zero interest credited to the account while the bank offsets any transaction charges with earnings credit.

- To allow beneficiaries to earn interest on their cash balance deposited in the bank, and not pay for the banking charges, the agency may choose to fund the costs associated with maintaining the checking account. The agency may also choose to use agency funds on deposit that accumulates bank earnings credit to offset some or all of the banking costs.

b) Interest paid should be allocated back to each beneficiary's account. The allocation should be done on a consistent basis. Monthly is suggested; quarterly is the minimum standard.
c) The agency must have written policies and procedures regarding the distribution of interest.
d) Beneficiaries are allowed a maximum amount of gross income per month before their benefits are affected. Interest is included in the calculation of monthly income. Therefore, the agency may wish to review whether monthly or some other time frame would be most appropriate for the distribution of interest income.

3. Cost of Administering the Collective Account
a) The agency may charge the individual beneficiary's specific account a fee for administering the Representative Payee Collective Account.
b) The agency must apply to the local SSA office to be approved as an entity who can charge a fee for payee services. The local SSA office will indicate which documents must be provided before blanket approval can be given. Once approval is granted, SSA will issue a note to the entity. Only then can the agency request of SSA, to charge a fee on a case by case basis. Each time the agency seeks permission to charge a fee; the client will receive a formal notice from SSA saying it is allowing the agency to charge an ongoing fee.
c) Maximum monthly fees are the lesser of 10% of their total benefits or $25 per month.
If they have a SSA disability related to drug and or alcohol addiction the fee can be the lesser of 10% of their benefits or $72 per month.

4. Collective Account Charges
a) Overdraft charges are generally a result of poorly managing the account and therefore should be the responsibility of the agency.
b) Stop payment and re-issuance charges could be charged to the individual beneficiary's account or the administrative account, dependent upon the cause of the stop payment. The agency should include criteria in their written policies and procedures.
    - Example: the client loses or misplaces the check and the original check

is not available; the charge could be to the individual beneficiary's account.
- Example: the check is "lost in the mail"; the charge could be to the administrative account.

c) Bank charges, e.g., transaction fees, monthly fees, could be charged to the individual beneficiary's account. There may be also charges from vendors other than the bank, such as a reorder of checks. The agency should include criteria in their written policies and procedures.
- Example: the methodology could be by the number of transactions, divided evenly by the number of individual beneficiary accounts, or by the beneficiary's month-end balance.

E. RESPONSIBILITIES OF THE AGENCY ACTING AS REPRESENTATIVE PAYEE

1. Per SSA, adults who are unable to manage their finances because of severe physical or mental limitations need payees.

a) SSA makes the final determination of whether a payeeship is warranted. SSA indicates that they have to have a payee because they are mentally incapable of handling or directing how their SSA benefits are used.
b) The State encourages persons with mental illness to assume as much responsibility for themselves as possible, including money management.
c) The payee receives the benefit with the full right and duty to expend it, in the best interests of the beneficiary, according to his or her best judgment.

2. Per SSA, representative payees are required by law to use benefits properly. Therefore, the agency has a legal and professional responsibility to see that the funds are used in accordance with (federal) Social Security Administration rules, regulations and guidelines.

3. Per SSA, if a payee misuses benefits, he or she must repay the misused funds. A payee convicted of misuse may be fined and/or imprisoned. Therefore, since the agency is the representative payee, individual staff could be held accountable for the misuse of benefits. The responsible staff person could be clinical or administrative, depending upon the circumstances.

4. The agency has a responsibility to have the appropriate internal controls in place to assure that the funds are not being misused. For the safety and security of staff and clients, cash transactions should be kept at a minimum. Payee checks should never be cashed through an agency staff person's personal account.

5. The agency might have working relationships with local or community vendors that enable the client to use certificates in lieu of cash. These could be grocery or restaurant certificates.

6. The agency has a responsibility to properly educate and train all staff persons who have an involvement with representative payee funds. This includes written guidelines as well as periodic education of federal and state rules and regulations as needed.

Often, the local Social Security office can provide materials and assistance.

F. AGENCY DISTRIBUTION OF DUTIES

1. The person who assists the client on a day-to-day basis through the case management function is generally the person who requests the payment of the expenditures. This individual has the primary responsibility to see that the funds being requested are being spent in accordance with SSA rules and guidelines.

2. The person who assists the client on a day-to-day basis through the case management function is generally the person who is aware of changes that may affect the client's eligibility for benefits or the amount of the benefit. Certain changes need to be reported to the local Social Security office. The actual reporting requirements may vary between the different funding sources. These changes include, but are not limited to: death, a change of residence, employment changes, receipt of additional government benefits, institutionalization (hospital, nursing home), imprisonment for a crime that carries a sentence of over one calendar month, changes in marital or living arrangements, or changes in income or resources.

3. The person who issues the payment of the expenditures has a general oversight responsibility to see that the funds are handled according to agency, state and SSA guidelines and those changes are reported.

4. The agency should have policies and procedures in place that can accommodate this distribution of duties.

G. GUIDELINES FOR THE USE OF BENEFICIARY'S FUNDS

Following is a list that includes, but is not limited to, examples of appropriate use of the beneficiary's funds. The funds are to be used for the beneficiary's basic immediate needs or saved for future foreseeable needs. Questions as to whether an expense is appropriate or not should be addressed to your local SSA office or other appropriate funding source.

1. Basic Needs: The first use of the beneficiary's funds is to meet the day-to-day needs for food and shelter. Shelter would include the basic cost of housing. Included in housing are rent and the cost of utilities. A guide for the representative payee to consider could be one-third of the benefit, if the beneficiary is living in subsidized housing.

2. Non-covered Health Related Expenses: This category includes medical and dental care not provided by Medicare, Medicaid or other third party payer.
    - Medical care: Included is the cost for physical care and a fee for mental health services based on the agency's sliding fee policies. In some communities, free or reduced medical care may be offered through local medical schools or other community organizations.
    - Dental care: In some communities, free or reduced dental care may be offered through local dental schools or other community organizations.

- Eyeglasses, hearing aids and other items necessary for good health care.
- Beneficiaries who are 27-10 certified are required to have medical care and emergency dental care. The agency should review the appropriate regulations to assure compliance. (CRS 27-10, 106 Certification for Treatment on an Outpatient Basis)

3. Assisting the Client to Become More Self-Sufficient: The agency may have a structured plan to assist the client to manage his or her own funds. This plan would gradually give the beneficiary more responsibility to manage and pay his or her own bills over a period of months. If the beneficiary fails to manage money in a responsible manner, the agency should repeat the plan or cancel the arrangement until a later date when the beneficiary is ready to begin the process of managing their own funds.

4. Personal Items: There are other items for the individual's personal comfort that would be considered necessary for the beneficiary's current needs. Personal needs include the cost of a telephone, clothing, and recreation. Recreation includes the cost of movies, concerts, magazine subscriptions or a special trip for the beneficiary. These expenses should be considered essential and not frivolous in nature.

5. Other: These items could include special training programs, school tuition or daily school expenses.

6. Special Purchases: Sometimes a beneficiary receives a large payment covering several months of benefits, or they may receive a rent rebate. The agency should assist the beneficiary in planning major purchases that are in the best interest of the beneficiary. The agency should make certain that any incidence of debt can be accommodated by the beneficiary's monthly income. Possible special purchases include:
    - A Home: Costs to consider are the down payment and a reasonable share of the monthly payment on a house owned wholly or in part by the beneficiary.
    - Home improvements: Costs of renovations to make the beneficiary's home safer and more accessible; home repairs.
    - Furniture: Purchases for the beneficiary's personal use as well as items that may be shared with other members of the household, such as a television.
    - A car: The agency should review whether the beneficiary's needs could be met through public transportation. The cost of car ownership should be carefully reviewed before large sums of money are committed. These costs include the down payment, monthly payments, and the cost of maintenance and insurance.

7. Limitation on charges to personal funds:

    a. No charge for handling personal needs trust funds shall be made to the client. Such charges should be included as part of the audited cost used to determine per diem resident maintenance charges.
    b. The facility shall not impose a charge against the personal funds of a resident for any item or service for which payment is made under the facility's per diem resident maintenance charge. Per diem maintenance charges include but are not limited to:

(1) Dietary services as required.
(2) Room/Bed Maintenance services as required.
(3) Training or education as required.
(4) An activities program as required.
(5) Routine personal hygiene items and services as required to meet the needs of the residents including but not limited to:

(a) Hair hygiene supplies, comb, brush, etc.
(b) Razor and shaving cream
(c) Toothbrush, toothpaste, dental floss.
(d) Mouthwash and deodorant.
(e) Towels, washcloths and tissues.
(f) Bath soap, disinfecting soaps including specialized cleansing agents when indicated to treat special skin problems or to fight and control infections.
(g) Basic personal laundry and bathing. (h) Sanitary napkins and related supplies.

c. The facility may not charge a client (or his or her representative) for any item or service not requested by the client.

8. Items and services the facility may charge to client's funds providing the following conditions are meet:

a. The item or service is requested by the client.
b. The facility informs the client that there will be a charge and what the charge will be.
c. Payment for the item or service is not provided within the per diem maintenance charges and alternative funding is not available from Medicaid, Medicare or other sources of public or private assistance.

Items and services chargeable to the client, provided the above listed conditions are met include:

a. Telephone
b. Television/radio for personal use.
c. Personal comfort items including tobacco products, notion and novelties, and confections.
d. Cosmetic and grooming items in excess of those included within the per diem maintenance charge and alternative sources of assistance.
e. Personal clothing.
f. Personal reading matter.
g. Gifts purchased on behalf of a resident. h. Flowers and plants.
i. Social events and entertainment offered outside the scope of the activities program included within the per diem maintenance charge.
j. Occasional specially prepared or alternative food requested in addition to or in place of the food generally prepared by the facility and paid for within the facility's per diem maintenance charge.

9. Amounts owed to former clients may be lawfully cleared from the accounts in the annual report required under the Unclaimed Property Act, CRS 38-13-110. A guide and reporting forms for the Unclaimed Property Program may be obtained from the Colorado State Treasurer, phone 303-894-2443.

Exhibit A: CMHC/ SUD Example Financial Statements

The following is a model financial statement following the AICPA Healthcare Audit Guide; however the appropriate audit guide should be followed. A CMHC provider may be awarded the Medicaid capitation contract in which case the CMHC/SUD is also considered a BHO. These BHOs should also file Exhibit B financial statements.

Additional examples can be found at the Electronic Municipal Market Access (EMMA) – Municipal Securities Rulemaking Board (MSRB) website here http://emma.msrb.org/ or at the Electronic Data Gathering, Analysis, and Retrieval system (EDGAR) at http://www.sec.gov/edgar/aboutedgar.htm. Links are provided in order to ensure providers have access to the most up to date sources. These sites in addition to the examples below are meant to serve as an example and providers are not required to match theses examples.

CMHC/SUD
BALANCE SHEETS
JUNE 30, XXXXND XXXX

ASSETS	XXXX	XXXX
CURRENT ASSETS		
Cash and cash equivalents	$_____	$_____
Short-term investments		
Client accounts receivable, less allowance for uncollectible accounts; XXXX $_____, XXXX $_____		
Medicaid receivable, less allowance for disallowed claims; XXXX $_____, XXXX $_____		
Medicare receivable, less allowance for disallowed claims; XXXX $_____, XXXX $_____		
Receivable from intermediary entity		
Estimated retroactive adjustment - third party payers		
Other receivables		
Supplies		
Prepaid expenses and other	_____	_____
Total Current Assets	_____	_____
INVESTMENTS		
Investments in and advances to equity investee		
Long-term investment	_____	_____
PROPERTY AND EQUIPMENT, At Cost		
Land and land improvements		
Buildings and leasehold improvements		
Equipment	_____	_____
Less accumulated depreciation	_____	_____
	_____	_____
OTHER ASSETS	_____	_____
	$_____	$_____

LIABILITIES AND NET ASSETS	XXXX	XXXX
CURRENT LIABILITIES		
Notes payable	$	$
Current maturities of long-term debt		
Incurred but not reported		
Accrued expenses		
Estimated retroactive adjustments - third party payers		
Deferred revenue		
Other		
Total Current Liabilities		
LONG-TERM DEBT		
Total Liabilities		
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Unrestricted		
Board Designated		
Unrestricted		
Temporarily restricted		
Permanently restricted		
	$	$

CMHC/
SUD

STATEMENTS OF OPERATIONS YEARS
ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
REVENUES AND GAINS		
Net client, Medicaid, Medicaid capitation, Medicare, insurance, third party and other service revenue	$	$
State revenue		
Public support		
Other		
EXPENSES		
Personnel		
Client related		
Occupancy		
Operating		
Depreciation and Amortization		
Provision for Uncollectible Accounts		
Professional fees		
Donated items		
OPERATING INCOME		
OTHER INCOME		
Investment income		
Income from investment in equity investee		
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$	$

CMHC/SUD

STATEMENTS OF CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
UNRESTRICTED NET ASSETS		
Excess of revenues over expenses	$	$
Net assets released from restrictions used for purchase of property and equipment		
Increase (decrease) in unrestricted net assets		
TEMPORARILY RESTRICTED NET ASSETS		
Net realized gains (losses) in restricted investments		
Net assets released from restrictions		
Increase (decrease) in temporarily restricted net assets		
PERMANENTLY RESTRICTED NET ASSETS		
Investment income permanently restricted		
Net realized gains on restricted investment		
Increase (decrease) in permanently restricted net assets		
INCREASE (DECREASE) IN NET ASSETS		
NET ASSETS, BEGINNING OF YEAR		
NET ASSETS, END OF YEAR	$	$

CMHC/SUD

STATEMENTS OF CASH FLOWS YEARS ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
CASH FLOW FROM OPERATING ACTIVITIES		
Change in net assets	$	$
Items not requiring (providing) cash:		
Depreciation and amortization		
Loss on investment in equity investee		
Net realized gain on investments		
Changes in:		
Client accounts receivable, net Medicare and Medicaid receivable Accounts payable and accrued expenses Other current assets and liabilities		
Net cash provided by (used in) operating activities		
CASH FLOWS FROM INVESTING ACTIVITIES		
Net purchases (sales) of investments		
Advance to and investment in equity investee		
Purchase of property and equipment		
Net cash provided by (used in) investing activities		
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal payments on long-term debt		
Proceeds from issuance of long-term debt		
Net cash provided by (used in) financing activities		
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS		
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR		
CASH AND CASH EQUIVALENTS, END OF YEAR	$	$
SUPPLEMENTAL CASH FLOW INFORMATION		
Cash paid for interest	$	$

Financial Statement Notes:

The notes to Financial Statements should follow current AICPA statements on Auditing Standards and the Health Care Audit Guide. In addition to those footnote disclosures that fulfill the accounting profession's reporting standards of adequate disclosure, the Office of Health and Rehabilitation Services requires the following:

1. A statement of how donated materials and services are recorded and valued by category, disclose donor, if material, such as county building.

2. Disclosure of CMHC ownership/affiliation with other corporations, foundations, etc., including an explanation of the type of relationship. Disclosure of financial data may be required -- see the AICPA Health Care Organizations.

3. Any material restricted funds should be identified with donor or grantor restrictions.

4. Any disclosure issued related to compliance with the Office of Health and Rehabilitation Services contract requirements. This would include amounts required for insurance reserves and "reinvestment plans" for deferred revenues.

5. Charity care.

Financial Statement Supplemental
Schedule: CMHC/SUD

SUPPLEMENTARY SCHEDULE OF
REVENUES YEAR ENDED JUNE 30,
XXXX

	Mental Health Services	SA Services	Other Services	Total
REVENUES				
Client service:				
Medicaid capitation, less deferred revenue of $				
Medicaid Hospital Alternatives				
Medicaid fee for service				
Rehab Option				
OBRA				
evaluations				
Other Medicaid				
Medicare partial hospitalization				
Medicare other services				
Client fees				
Private/third-party				
Other contracts				
Net client service revenue				
Government:				
Federal contracts				
Colorado Department of Human Services				
Office of Health and Rehabilitation				
General fund				
Block grant				
Other				
Division of Youth Services				
Total Colorado				
Local government				
County Municipal				
School district				
Total Local Government				
Total Government				
Public Support: Donated services Donated hospital				

Donated Medications				
Donated building space				
Total Public Support				
Other income Interest				
Management fees				
Other				
Total other income				
Total revenues	$	$	$	$

Exhibit B: BHO Example Financial Statements

A BHO may be a partnership formed to contract with the State for the Medicaid capitation contract. The partnership may consist of CMHCs, other providers of services and/or managed care companies.

The partners may be either for-profit or not-for-profit entities. The not-for-profit entities may be either private or governmental. All not-for-profit entities are direct to the Example balance sheets in Exhibit C.

These BHOs should follow Exhibit B financial statements.

Additional example statements can be found at the Electronic Municipal Market Access (EMMA) – Municipal Securities Rulemaking Board (MSRB) website here http://emma.msrb.org/ or at the Electronic Data Gathering, Analysis, and Retrieval system (EDGAR) at http://www.sec.gov/edgar/aboutedgar.htm. Links are provided in order to ensure providers have access to the most up to date sources. These sites in addition to the examples below are meant to serve as an example and providers are not required to match theses examples.

BHO

BALANCE SHEETS JUNE 30, XXXX AND XXXX

ASSETS	XXXX	XXXX
CURRENT ASSETS		
Cash and cash equivalents	$	$
Other contracts receivable		
Prepaid expenses and other		
Total Current Assets		
PROPERTY AND EQUIPMENT, At Cost		
Furniture and fixtures		
Equipment		
Less accumulated depreciation		
OTHER ASSETS		
Deposits		
Organization costs, less accumulated amortization of $_____ XXXX, $_____ XXXX		
LIABILITIES AND NET ASSETS	XXXX	XXXX
CURRENT LIABILITIES		
Accounts payable	$	$
Accrued expenses		
Incurred but not reported		
Deferred revenues		
Other		
Total Liabilities		
NET ASSETS		
Unrestricted		
Board designated		
Unrestricted		
	$	$

BHO

STATEMENTS OF OPERATIONS AND CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
REVENUE		
Medicaid capitated payments, less amounts deferred To reinvestment plan ($)	$	$
Medicaid Hospital Alternative		
	( )	( )
Net Medicaid Revenue		
EXPENSES		
Sub-capitated costs:		
CMHC 1		
CMHC 2		
CMHC 3		
Inpatient		
Alternative treatment unit		
Outpatient		
Residential		
Purchased services		
Salaries		
Depreciation		
Other costs (reflect separately where meaningful to users)		
Operating Income		
OTHER INCOME		
Interest		
Other		
Total Other Income		
INCREASE IN NET ASSETS		
NET ASSETS, BEGINNING OF YEAR		
NET ASSETS, END OF YEAR	**$**	**$**

BHO

STATEMENTS OF CASH FLOWS YEARS ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
CASH FLOWS FROM OPERATING ACTIVITIES		
Change in net assets	$	$
Items not requiring (providing) cash:		
Depreciation and amortization		
Change in:		
Other contracts receivable		
Accounts payable and accrued expenses		
Deferred revenues		
Incurred but not reported		
Other current assets and liabilities		
Net cash provided by (used in) operating activities		
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of property and equipment		
Net cash provided by (used in) investing activities		
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS		
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR		
CASH AND CASH EQUIVALENTS, END OF YEAR	$	$

BHO

NOTES TO FINANCIAL STATEMENTS
JUNE 30, XXXX AND XXXX

The footnotes should include all disclosures necessary for a fair presentation of financial position and results of operation. The disclosures for a health maintenance organization contained in the Health Care Guide can be used as examples.

Of particular importance is the disclosure of dependence on the contract for revenues, the dependence on internal providers to deliver services, including geographical areas, the nature of the deferred revenues and the existence of the State authorized plan for use of the deferred revenues. Additional disclosures would include the method of computing incurred but not reported claims, related party transactions and balances, and board designated net assets.

Exhibit C: Not-For-Profit Example Financial Statement

A provider may also register as a not-for-profit entity. This provider will not operate under a traditional medical model of reporting costs. A not-for-profit organization does not declare its surplus revenues as profits or dividends.

Additional example statements and information can be found at the Accounting Standards Codification (ASC) website here https://asc.fasb.org/home. A link is provided in order to ensure providers have access to the most up to date sources. Examples on this site in addition to the examples below are meant to serve as an example and providers are not required to match theses examples.

Not-for-Profit Entity – Statements of Financial Position

.		
Assets:	**Year I**	**Year II**
Cash and cash equivalents	$	$
Account and interest receivable	$	$
Inventories and prepaid expenses	$	$
Contributions receivable	$	$
Short-term investments	$	$
Assets restricted to investment in land, buildings and equipment	$	$
Land, building, and equipment	$	$
Long-term investments	$	$
	$	**$**
Liabilities and Net Assets:		
Accounts payable	$	$
Refundable advance	$	$
Grants payable	$	$
Notes Payable	$	$
Annuity obligations	$	$
Long-term debt	$	$
	$	**$**
Net Assets:		
Unrestricted	$	$
Temporarily restricted (Note B)	$	$
Permanently restricted (Note C)	$	$
	$	**$**
Total Liabilities and Net Assets:	**$**	**$**

Not-for-Profit – Statement of Activities - Format A

In Format A, information is presented in a single column which most easily accommodates presentation of multiyear information.

Changes in Unrestricted Net Assets:	
Revenues and gains:	$
Contributions	$
Fees	$
Income on long-term investments (Note E)	$
Other investment income (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Other	$
Total unrestricted revenues and gain	$
Net assets released from restrictions (Note D):	$
Satisfaction of program restrictions	$
Satisfactions of equipment acquisition restrictions	$
Expiration of time restrictions	$
Total net assets released from restrictions	$
Total unrestricted revenues, gains, and other support	$
Expenses and losses:	$
Program A	$
Program B	$
Program C	$
Management and general	$
Fund raising	$
Total expenses (Note F)	$
Fire loss	$
Total expenses and losses	$
Increase in unrestricted net assets	**$**
Changes in Temporarily Restricted Net Assets:	
Contributions	$
Income on long-term investments (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Actuarial loss on annuity obligations	$
Net assets released from restrictions (Note D)	$
Decrease in temporarily restricted net assets	**$**

Not-for-Profit – Statement of Activities - Format A (Continued)

Changes in Permanently Restricted Net Assets:	
Contributions	$
Income on long-term investments (Note E)	$
Net unrealized gains on long-term investments (Note E)	$
Increase in permanently restricted net assets	$
Increase in Net Assets	**$**
Net Assets at the beginning of year	**$**

Not-for-Profit Entity - Statements of Financial Position – Format B

Format B reports the same information in a columnar format with a column for each class of net assets and adds an optional total column. That format makes evident that the effects of expiations on donor restrictions result in reclassifications between classes of net assets. It also accommodates presentation of aggregated information about contributions and investment income for the entity as a whole.

Revenues, Gains, and Other Support:	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Contributions	$	$	$	**$**
Fees	$	$	$	**$**
Income on long-term investments (Note E)	$	$	$	**$**
Other investment income (Note E)	$	$	$	**$**
Net unrealized and realized gains on long-term investments (Note E)	$	$	$	**$**
Other	$	$	$	**$**
Net assets released from restrictions (Note D):	$	$	$	**$**
Satisfaction of program restrictions	$	$	$	**$**
Satisfaction of equipment acquisition	$	$	$	**$**
Expiration of time restrictions	$	$	$	**$**
Total Revenues, Gains, and Other Support	**$**	**$**	**$**	**$**
Expenses and Losses:	$	$	$	$
Program A	$	$	$	$
Program B	$	$	$	$
Program C	$	$	$	$
Management and general	$	$	$	$
Fund raising	$	$	$	$
Total Expenses (Note F)	**$**	**$**	**$**	**$**
Fire loss	$	$	$	$
Actuarial loss on annuity obligations	$	$	$	$
Total expenses and losses	**$**	**$**	**$**	**$**
Change in net assets	$	$	$	$
New assets at beginning of year	**$**	**$**	**$**	**$**

Not-for-Profit Entity - Statements of Financial Position – Format C (1/2)

Format C reports information in two statements with summary amounts from a statement of revenues, expenses, and other changes in unrestricted net assets (part 1 of 2) articulating with a statement of changes in net assets (part 2 of 2). Alternative format for the statement of changes in net assets-a single column and a multicolumn- are illustrated. The two statement approach of Format C focuses attention on changes in unrestricted net assets. That format may be preferred by NFPs that view their operating activities as excluding receipts of donor-restricted revenues and gains from contributions and investment income.

Unrestricted Revenues and Gains:	
Contributions	$
Fees	$
Income on long-term investments (Note E)	$
Other investment income (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Other	$
Total Unrestricted Revenues and Gains:	**$**
Net Assets Released from Restrictions (Note D):	
Satisfaction of program restrictions	$
Satisfaction of equipment acquisition restrictions	$
Expiration of time restrictions	$
Total Net Assets Released from Restrictions	**$**
Total Unrestricted Revenues, Gains, and Other Support:	**$**
Expenses and Losses:	
Program A	$
Program B	$
Program C	$
Management and general	$
Fund raising	$
Total Expenses (Note F)	**$**
Fire Loss	$
Total unrestricted expenses and losses	**$**
Increase in Unrestricted Net Assets:	**$**

Not-for-Profit Entity - Statements of Financial Position – Format C (2/2)

Unrestricted Net Assets:	
Total unrestricted revenues and gains	$
Net assets released from restrictions (Note D)	$
Total unrestricted expenses and losses	$
Increase in unrestricted net assets	$
Temporarily Restricted Net Assets:	
Contributions	
Income on long-term investments (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Actuarial loss on annuity obligations	$
Net assets released from restrictions (Note D)	$
Decrease in temporarily restricted net assets	$
Permanently Restricted Net Assets:	
Contributions	$
Income on long-term investments (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Increase in permanently restricted net assets	$
Increase in Net Assets:	$
Net Assets at the Beginning of Year:	$
Net Assets at the End of Year:	$

Not-for-Profit Entity - Statements of Financial Position – Format C (2/2) Alternate

Revenues, Gains, and Other Support:	**Unrestricted**	**Temporarily Restricted**	**Permanently Restricted**	**Total**
Unrestricted revenues, gains, and other supports	$	$	$	**$**
Restricted revenues, gains, and other support:	$	$	$	**$**
Contributions	$	$	$	**$**
Income on long-term investments (Note E))	$	$	$	**$**
Net unrealized and realized gains on long-term investments (Note E)	$	$	$	**$**
Net Assets released from restrictions (Note D)	$	$	$	**$**
Total Revenues, gains, and other support	**$**	**$**	**$**	**$**
Expenses and Losses:				
Unrestricted expenses and losses	$	$	$	**$**
Actuarial loss on annuity obligations	$	$	$	**$**
Total expenses and losses	$	$	$	**$**
Change in net assets	**$**	**$**	**$**	**$**
Net Assets at Beginning of Year	**$**	**$**	**$**	**$**
Net Assets and End of Year:	**$**	**$**	**$**	**$**

Exhibit D: Supplementary Unit Cost Reports

CMHC
Supplementary Cost F

NOTE: INSERT LINK TO SUD SUPPLEMENTARY COST REPORT

Exhibit E: Related Party Transactions

	1 Name of Related Party	2 Description of Goods/Services Purchased	3 Amount of Transaction/Payment to Related Party	4 Fair Market Value of Goods/Services Purchased (As Reported on Annual Financial Statement)
1			$	$
2			$	$
3			$	$
4			$	$
5			$	$
6			$	$
7			$	$
8			$	$
9			$	$
10			$	$
11			$	$
12			$	$
13			$	$
14			$	$
15			$	$
	TOTAL		**$**	**$**

Exhibit F: Manage Service Organization Balance Sheets

JUNE 30, XXX2 AND XXX1

ASSETS	XXX2	XXX1
CURRENT ASSETS		
Cash and cash equivalents	$	$
Short-term investments		
Client accounts receivable, less allowance for uncollectible		
Other receivables		
Supplies		
Prepaid expenses and other		
Total Current Assets		
INVESTMENTS		
Investments in and advances to equity investee		
Long-term investment		
PROPERTY AND EQUIPMENT, At Cost		
Land and land improvements		
Buildings and leasehold improvements		
Equipment		
Less accumulated depreciation		
OTHER ASSETS		
	$	$

MANAGED SERVICE ORGANIZATION
BALANCE SHEETS
JUNE 30, XXX2 AND XXX1

LIABILITIES AND NET ASSETS	XXX2	XXX1
CURRENT LIABILITIES		
Notes payable	$	$
Current maturities of long-term debt		
Incurred but not reported		
Accrued expenses		
Estimated retroactive adjustments - third party payers		
Deferred revenue		
Other		
Total Current Liabilities		
LONG-TERM DEBT		
Total Liabilities		
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Unrestricted		
Board Designated		
Unrestricted		
Temporarily restricted		
Permanently restricted		
	$	$

MANAGED SERVICE ORGANIZATION

STATEMENTS OF OPERATIONS YEARS ENDED JUNE 30, XXX2 AND XXX1

	XXX2	XXX1
REVENUES AND GAINS		
State of Colorado, OBH	$	$
Federal revenues		
Other State of Colorado Revenues		
Medicaid		
Insurance, third party and other service revenue		
Client fees		
Public support		
Other		
EXPENSES		
Operating expenses:		
External Providers: (list all over $50,000)		
Agency A		
Agency B …		
Detoxification		
Residential Services		
Outpatient Services		
Additional Family Services		
Administrative Expenses:		
Salaries, wages and benefits		
Depreciation		
Other Costs (detail to extent necessary to be meaningful to users)		
Donated items		
OPERATING INCOME		
OTHER INCOME		
Investment income		
Income from investment in equity investee		
INCREASE (DECREASE) IN UNRESTRICTED NET ASSETS	$	$

MANAGED SERVICE ORGANIZATION

STATEMENTS OF CHANGES IN NET ASSETS
YEARS ENDED JUNE 30, XXX2 AND XXX1

	XXX2	XXX1
UNRESTRICTED NET ASSETS		
Excess of revenues over expenses	$	$
Net assets released from restrictions		
Increase (decrease) in unrestricted net assets		
TEMPORARILY RESTRICTED NET ASSETS		
Net realized gains (losses) in restricted investments		
Net assets released from restrictions		
Increase (decrease) in temporarily restricted net assets		
PERMANENTLY RESTRICTED NET ASSETS		
Investment income permanently restricted		
Net realized gains on restricted investment		
Increase (decrease) in permanently restricted net assets		
INCREASE (DECREASE) IN NET ASSETS		
NET ASSETS, BEGINNING OF YEAR		
NET ASSETS, END OF YEAR	$	$

MANAGED SERVICE ORGANIZATION

STATEMENTS OF CASH FLOWS YEARS ENDED JUNE 30, XXX2 AND XXX1

	XXX2	XXX1
CASH FLOW FROM OPERATING ACTIVITIES		
Change in net assets	$	$
Items not requiring (providing) cash:		
Depreciation and amortization		
Loss on investment in equity investee		
Net realized gain on investments		
Changes in:		
Client accounts receivable, net Medicare and Medicaid receivable Accounts payable and accrued expenses Other current assets and liabilities		
Net cash provided by (used in) operating activities		
CASH FLOWS FROM INVESTING ACTIVITIES		
Net purchases (sales) of investments		
Advance to and investment in equity investee		
Purchase of property and equipment		
Net cash provided by (used in) investing activities		
CASH FLOWS FROM FINANCING ACTIVITIES		
Principal payments on long-term debt		
Proceeds from issuance of long-term debt		
Net cash provided by (used in) financing activities		
NET INCREASE (DECREASE) IN CASH AND CASH EQUIVALENTS		
CASH AND CASH EQUIVALENTS, BEGINNING OF YEAR		
CASH AND CASH EQUIVALENTS, END OF YEAR	$	$
SUPPLEMENTAL CASH FLOW INFORMATION		
Cash paid for interest	$	$

MANAGED SERVICE ORGANIZATION

NOTES TO FINANCIAL STATEMENTS
YEARS ENDED JUNE 30, XXX2 AND XXX1

The notes to Financial Statements should follow current AICPA statements on Auditing Standards and the Health Care Audit Guide. In addition to those footnote disclosures that fulfill the accounting profession's reporting standards of adequate disclosure, the Office of Health and Rehabilitation Services requires the following:

1. A statement of how donated materials and services are recorded and valued by category, disclose donor, if material, such as county building.

2. Disclosure of MSO ownership/affiliation with other corporations, foundations, etc., including an explanation of the type of relationship. Disclosure of financial data may be required -- see Audits of Health Care Organizations.

3. Any material restricted funds should be identified with donor or grantor restrictions.

4. Any disclosure issued related to compliance with the OBH contract requirements. This would include amounts required for insurance reserves and "reinvestment plans" for deferred revenues from capitated care contracts.

MANAGED SERVICE ORGANIZATION
SUPPLEMENTAL SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXX2

	SA Services	Other Services	Total
REVENUES			
Client service:			
Medicaid capitation, less deferred revenue of $_____			
Medicare other services			
Client fees			
Private/third-party			
Other contracts			
Net client service revenue			
Government:			
Federal contracts			
Colorado Department of Human Services			
Substance Abuse:			
Detoxification			
Outpatient			
Residential			
Additional Family Services			
Administrative			
SA Sub-total			
Division of Youth Services			
Other			
Total Colorado			
Local government			
County			
Alcohol and Drug Contracts			
General funds			
Municipal			
School districts			
Total Local Government			
Total Government			
Public Support: Donated			
services Donated			
hospital Donated			
building space			
Total Public Support			
Other income Interest			
Management fees			
Other			

Total other income			
Total revenues	$	$	$

MANAGED SERVICE ORGANIZATION

SUPPLEMENTARY SCHEDULE OF ALCOHOL AND DRUG ABUSE EXPENSES
YEAR ENDED JUNE 30, XXX2

		Outpatient & Residential	Addl Family	General and
Personnel:				
Salaries	$	$	$	$
$				
Employee benefits				
Contractual				
Client:				
Purchased Services (External Network)				
Emergency Room Costs				
Food				
Medical & laboratory				
Medications				
Purchases from other providers				
Client expenses/supplies/travel				
Occupancy:				
Maintenance & supplies				
Insurance, property				
Rent & real estate taxes				
Utilities				
Operating:				
Amortization & Depreciation				
Bad debt expense				
Dues, fees, licenses & subscriptions				
Equipment rental, lease & maintenance				
Insurance				
Interest				
Office supplies				
Postage/printing/photocopying				
Telephone & pagers				
Travel/conference/staff development				
Vehicle operation and maintenance				
Other expenses				
Professional fees:				
Audit and accounting				
Legal				
Other consultants				
Donated items:				
Materials				

Building space					
Volunteer services					
Hospital care					
Total Expenses	$	$	$	$	$

Exhibit G: Sub – Recipient of MSO Supplemental Schedule

REVENUES YEAR ENDED JUNE 30, XXX2

	SA Services	Other Services	Total
REVENUES			
Client service:			
MSO revenue			
Medicaid			
Medicare			
Client fees			
Private/third-party			
Other contracts			
Net client service revenue			
Government:			
Federal contracts			
Local government			
County			
Alcohol and Drug Contracts			
General funds			
Municipal			
School districts			
Total Local Government			
Total Government			
Public Support: Donated			
services Donated			
hospital Donated			
building space			
Total Public Support			
Other income			
Interest			
Other			
Total other income			
Total revenues	$	$	$

SUB-RECIPIENT OF MSO SUPPLEMENTARY SCHEDULE OF EXPENSES YEAR ENDED JUNE 30, XXX2

		Program	Program	General and
Personnel:				
Salaries	$	$	$	$
$				
Employee benefits				
Contractual				
Client:				
Purchased Services (External Network)				
Emergency Room Costs				
Food				
Medical & laboratory				
Medications				
Purchases from other providers				
Client expenses/supplies/travel				
Occupancy:				
Maintenance & supplies				
Insurance, property				
Rent & real estate taxes				
Utilities				
Operating:				
Amortization & Depreciation				
Bad debt expense				
Dues, fees, licenses & subscriptions				
Equipment rental, lease & maintenance				
Insurance				
Interest				
Office supplies				
Postage/printing/photocopying				
Telephone & pagers				
Travel/conference/staff development				
Vehicle operation and maintenance				
Other expenses				
Professional fees:				
Audit and accounting				
Legal				
Other consultants				
Donated items:				
Materials				
Building space				
Volunteer services				

Hospital care					
Total Expenses					
Allocation of General and Admin				( )	
Program Costs	$	$	$	$ -0-	$

Exhibit H: Glossary of Managed Care Terms

This glossary is intended to help independent auditors and staff of BHOs to better understand the issues involved in the Medicaid Capitation Program. It is not intended to be a complete list of managed care terms.

Access - The availability and appropriateness of a consumer's entry into a relationship with a health care provider and/or system.

Actuarial - Having to do with probabilities. Actuarial studies performed for managed care plans normally consist of projections of utilization and costs of specific benefits for a defined population.

Actuary - An accredited, professionally trained person in insurance mathematics who calculates rates, reserves, dividends, and other valuations and also makes statistical studies and reports.

Acute Care - Health care provided to treat conditions that are short term or episodic in nature.

Ambulatory Care - Health services rendered in a hospital outpatient facility, a clinic, or a physician's office; often synonymous with the term "outpatient care." The term usually implies that an overnight stay in a health care facility is not necessary.

Capitation - A method of payment for health care services in which a physician, hospital, or provider group is paid a fixed amount (typically monthly) for each person in a plan regardless of the actual number or nature of services provided. This is the type of payment structure commonly associated with health maintenance organizations (HMOs).

Case Management - The monitoring, planning, and coordination of treatment provided to patients with conditions requiring high cost or extensive services. Case management is intended to ensure an appropriate and cost-effective course of treatment in an appropriate setting. An itemized statement of services provided by a health care provider for a given patient, usually for one episode of care or set of services with a related charge for services provided. It is submitted to a health benefit plan for payment.

Clinical Data Base - The collection of clinical information from all episodes of patient care.

Continuum of Care- This term refers to the ability to provide health care along the entire spectrum of patient needs, from prevention and wellness at one end of the spectrum through primary, acute and long-term care at the other end of the spectrum.

Cost - What it takes to deliver service. Cost is determined by facilities' design, systems efficiency, information, supplies, human resources and the cost disposition among all individuals.

Culture - The basic pattern of assumptions, beliefs, attitudes and behaviors shared by member of an organization. The culture of an organization shapes the working style, activities and goals of its members and can evolve over time in both planned and unplanned ways.

Decentralized - The reallocation of resources and functions out of a centralized department to a location or locations closer to customers and patients.

Drivers of Cost - Drivers are the elements of operational and organizational design, which determine the level of cost at which care is delivered. For example, the number of layers in an organization influences the administrative costs of the organization. The way a process is designed influences both the cost of completing the process as well as the quality of the process' output.

Gatekeeper - A term used to describe the role of the primary care physician (PCP) in a managed care environment. The primary care physician is primarily responsible for all medical treatment rendered, making referrals as necessary and monitoring the patient through the course of treatment. Alternatively, the term describes third party monitoring of care to avoid excessive costs by allowing only appropriate and necessary care.

Center for Medicare and Medicaid Services (CMS) – The US Government agency responsible for administering Medicare and Medicaid (formerly Healthcare Financing Authority).

Holistic - A holistic approach in health care attends to the patient/client's mind, body and spiritual needs. Patients/clients are cared for in an environment, which is sensitive to their beliefs, values and culture. The environment promotes health so that patients/clients and staff are in a state of harmony with one another.

Length of Stay - The length of an inpatient's stay in a hospital or other health care facility. It is one measure of use of health facilities, reported as an average number of days spent in a facility per admission or discharge.

Long-Term Care - Method of providing care to individuals who require full-time monitoring and treatment over an extended period of time, but do not require acute inpatient care.

Management Service Organization (MSO) - Usually a wholly owned subsidiary of a health system that purchases and manages assets, negotiates care contracts, and provides other administrative and managerial services.

Medicaid - State programs of public assistance to persons regardless of age whose income and resources are insufficient to pay for health care. Title XIX of the Federal Social Security Act provides matching federal funds for financing state Medicaid programs.

Medicare - A federally sponsored program which provides hospital benefits and supplementary medical care services to those age 65 and over, as well as certain other eligible individuals. It was created by Title XVIII of the 1965 amendments to the Social Security Act.

Medicare Part A - Hospitalization insurance for Medicare-covered individuals.

Medicare Part B- Physician and ambulatory care insurance for Medicare-covered individuals. Medicare Partial Hospitalization for community mental health centers is a Part B benefit, paid by a Part A intermediary.

Network - A formally integrated group of providers working together with a common vision and goal. They jointly provide services through an integrated continuum of preventive and primary care, inpatient hospital care, alternative inpatient care, ambulatory care, transitional care and long-term or chronic care.

Outcomes - A measurement of the results of treatment, medications, and procedures for a health care consumer.

Per Diem Cost - The negotiated daily payment rate for delivery of services in one day regardless of actual services provided. Per diems can also be developed by the type of care provided, e.g., one per diem rate for acute care, a different rate for intensive care, etc.

Per Member Per Month - The ratio of some health care service or cost divided into the number of members in a particular capitated group on a monthly basis.

Preventative Health Care - Health care that has as its aim the prevention of disease, injury, or the worsening of an illness or condition before it occurs, thus focusing on keeping patients well rather than treating them once they are sick or have decompensated.

Quality of Care - Quality generally includes the appropriateness and medical or clinical necessity of care provided, the appropriateness and clinical expertise of the provider who renders the care, and the condition of the physical plant in which services are provided. Two methods for measuring quality are process evaluation (how care is provided) and outcomes' measurement (whether the desired result is achieved).

Risk - The change or possibility of loss. The sharing of risk is often employed as a utilization control mechanism within the managed care setting. Risk is also defined in insurance terms as the probability of loss associated with a given population.

Risk Pool - A portion of provider fees or capitation payments that are withheld as financial reserves to cover unanticipated utilization of services in an alternative delivery system.

Service - Customer defined and measured by customer satisfaction. It is an individualized and responsive collaboration with the customer. Service is delivered with respect, dignity, caring and compassion for the customer by individuals who are committed to and take pride in their work.

Sub-acute Care - Skilled, in-patient care provided in a distinct unit associated with a hospital; in a "stand-alone" sub-acute care facility; or, in specially licensed nursing home beds. This care is often required between an acute illness and convalescence or long-term care.

Utilization - The amount and rate at which patients/consumers use health care services. Utilization statistics are often used as a measure of the efficiency and appropriateness of health care services.

Utilization Management/Review/Control - A systematic means for reviewing and controlling patients' use of medical/clinical care services and providers' use of health care resources. It usually involves data collection, review and/or authorization, especially for services such as specialist referrals and emergency room use and particularly costly services such as hospitalization. UR is frequently used to curtail the provision of inappropriate services and/or to ensure that services are provided in the most cost-effective manner

Exhibit I: Fiscal and Statistical Indicators - Supplementary Audit Schedules

Forms for Behavioral Health Organizations

Please open the embedded workbook below to find the forms:

BHO F&S Report

Exhibit J: Third Party Liability Reporting

BHO/CMHC: _____

Date Submitted: _____

Fiscal Year: _____

TPL TYPE	DATE OF SERVICE		TOTAL AMOUNT
	Prior FY	Current FY	
Claim-Specific Adjudication			
Post-Pay Adjudication			
Post-Pay Adjudication for Pre-Paid Entities			
TOTAL			

Exhibit K: Instructions Manual Web-Based Cost Report

The instructions manual for the online web-based cost report for SUD providers is located at: INSERT Web Address

[i] Definitions are as set forward in the OMB Circular A-87, Cost Principles for State, Local and Indian Tribal Governments. Items of cost determined to be either direct versus indirect are derived from the *Uniform Chart of Accounts and Financial Reporting for Behavioral Health Providers* (Revised 2004) including corresponding account numbers

[ii] Definitions of multiple-base indirect cost allocation is as set forward in the OMB Circular A-122, Cost Principles for Non-Profit Organizations

[iii] Department of Health & Human Services, Centers for Medicare & Medicaid Services, The Provider Reimbursement Manual, Part 1. Chapter 2, Interest Expense, October, 2004