2018

Behavioral Health Accounting and Auditing Guidelines

COLORADO
Department of Health Care Policy & Financing

COLORADO
Office of Behavioral Health
Department of Human Services

Updated June 2018 for Fiscal Year Ended June 30, 2018

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Chapter 1: Overview

PURPOSE

These guidelines, in conjunction with the AICPA Audit and Accounting Guide, Health Care Entities (most recent edition) and the AICPA Audit and Accounting Guide, Not-For-Profit Entities (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 that are included in the Uniform Service Coding Standards Manual, regardless of funding source and/or program;
- capture Relative Value Unit (RVU) weights for services with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual; and
- calculate a base cost per unit of service unique to each center or clinic for RVU-based services provided with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual, regardless of funding source and/or program.

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) and the Colorado Department of Health Care Policy and Financing (HCPF) regardless of the source of the funds (state or federal). Funded providers will file an annual financial statement (AFS), per Exhibit A in the appendix, as well as a Colorado Unit Cost

Report, per Exhibit F in the appendix, with OBH and HCPF. These guidelines are also applicable to Behavioral Health Organizations (BHO) under contract with HCPF to administer the Medicaid Mental Health Capitation Program. BHO's 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

On an annual basis, a committee will convene to evaluate these 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. Any changes needed to the Guidelines must be agreed upon and implemented by June 30th for implementation in the new fiscal year. OBH and HCPF, as the grant making and funding entities, will have the final authority in approving updates to the Guidelines to ensure compliance with state and federal guidelines.

SUBMISSION TIMELINE AND DEADLINES

November 30: Submission by CMHC's of annual financial statement and Colorado Unit Cost Report to HCPF and OBH. HCPF-sponsored audit of Colorado Unit Cost Report for all providers begins.

March 1: Proposed audit findings are delivered to CMHC's for their review and consideration.

March 10: All CMHC responses must be received by Colorado Unit Cost Report auditors.

March 15: HCPF-sponsored audit of Colorado Unit Cost Report for all providers concludes. All cost reports are finalized.

If any of these dates fall on a weekend or holiday, the due dates will be the following business day.

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 – Consistency of Costs
Standard 2 – Natural and Functional Classifications
Standard 3 – Direct and Indirect Cost Definitions
Standard 4 – Cost Allocation Methodologies
Standard 5 – Unallowable Costs
Standard 6 – Reporting Period

Standard 1: Consistency of Costs

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

Reasonable documentation of information trails is required to permit tracking of classified costs to the reported actual costs. Comparative reports of historical costs of operations, programs and services also require adherence to the same rules of consistency. Providers are 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 with essential information for contract management.

Standard 2: Natural and Functional Classifications

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. These terms are defined in the AICPA Audit and Accounting Guide, Not-for-Profit Entities (most recent edition) and AICPA Audit and Accounting Guide, Health Care Entities (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.

Note that the functional classifications are defined by the columns on Schedule 1 of the Colorado Unit Cost Report (described in Chapter 4).

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.

Note that the natural classifications are used in the annual financial statements (described in Chapter 3) and are defined by the rows on Schedule 1 of the Colorado Unit Cost Report (described in Chapter 4)

Total expenses categorized under the natural classifications in the annual financial statements must reconcile to Schedule 1 of the Colorado Unit Cost Report (Exhibit F).

Standard 3: Direct and Indirect Cost Definitions

Items of cost incurred by the providers should be classified consistently between direct costs and indirect costs as defined below:

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 and/or programs when they are incurred in support of a specific cost center and/or program. 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, such as supplies for a specific program.

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.

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 or a range of programs.

Standard 4: Cost Allocation Methodologies

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

Method 1: Direct Assignment
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.

Method 2: Allocation Across Specific Programs
Costs that directly benefit more than one cost center and/or program should be allocated to the cost centers and/or programs that benefit from them. An example is 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 and/or programs, it is allocated to the benefiting cost centers and/or programs based on a statistic, such as square footage.

Method 3: Allocation Across All Programs
Costs that benefit the organization as a whole and are not directly traceable to any specific cost center and/or program separately should be allocated to all programs and/or cost centers. Indirect costs that benefit all programs and/or cost centers include administrative costs such as the Executive Director, Finance/Accounting department and the IT department.

The methods for allocating costs must produce an equitable and consistent distribution of costs (e.g. all activities that benefit from the indirect costs, including unallowable activities, must receive an appropriate allocation of indirect costs).

When allocating costs, whether allocating direct costs to multiple benefiting cost centers and/or programs or allocating indirect costs to all cost centers and/or programs, statistics and methodologies must be documented and maintained in order to support the distribution of such costs. Such documentation must be available upon request.

Examples of acceptable methods for allocating salaries and other personnel costs to different functional expense classifications include:

- Journal entries in the accounting system supported by contemporaneous time records;
- Service activity logs or unit increments captured during the cost reporting period; or
- Time study for a minimum of four weeks performed during the cost reporting period. Time study must be based on documented records, reviewed periodically, and adjusted accordingly.

Employees paid in full or in part with federal funds must adhere to Standards For Documentation of Personnel Expenses identified in 2 CFR 200.430. 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. Any allocation of costs must reasonably assign costs to the columns in accordance with generally accepted accounting principles.

The following table provides the suggested statistics that providers can use to allocate costs to cost centers and/or programs. Providers must maintain and make available supporting documentation of their allocation methodologies. This 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 and/or Program)**
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.

Standard 5: Unallowable Costs

Certain costs are unallowable for reimbursement by OBH and HCPF or only allowable in certain situations. The accounting system needs to be established for these costs to be readily identified so they can be segregated from the allowable cost categories. 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: Unallowable advertising and public relations costs include the following:

- All advertising and public relations costs other than as specified below:

    - The only allowable advertising costs are those which are solely for:
        - The recruitment of personnel;
        - The procurement of goods and services for the performance of a specific contract;
        - The disposal of scrap or surplus materials acquired in the performance of a specific contract except when entities are reimbursed for disposal costs at a predetermined amount; or
        - Program outreach and other specific purposes necessary to meet the requirements of a specific contract.
    - The only allowable public relations costs are:
        - Costs specifically required by a specific contract;
        - Costs of communicating with the public and press pertaining to specific activities or accomplishments which result from performance of a specific contract (these costs are considered necessary as part of the outreach effort for a specific contract); or
        - Costs of conducting general liaison with news media and government public relations officers, to the extent that such activities are limited to communication and liaison necessary to keep the public informed on matters of public concern, such as notices of funding opportunities, financial matters, etc.
- Costs of meetings, conventions, convocations, or other events related to other activities of the entity, including:
    - Costs of displays, demonstrations, and exhibits;
    - Costs of meeting rooms, hospitality suites, and other special facilities used in conjunction with shows and other special events; and
    - Salaries and wages of employees engaged in setting up and displaying exhibits, making demonstrations, and providing briefings;
- Costs of promotional items and memorabilia, including models, gifts, and souvenirs;
- Costs of advertising and public relations designed solely to promote the entity to increase patient utilization.

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.

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: The value of contributions and donations made to other organizations or received from other organizations, including cash, property such as material and building space, services such as volunteer services or hospital care, or any in-kind such as donated psychiatric medications, 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 is 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 entertainment, including amusement, diversion, and social activities and any associated costs such as meals, lodging, rentals, transportation, and gratuities are unallowable, except where specific costs that might otherwise be considered entertainment have a programmatic purpose and are authorized either in the approved budget for a contract award or with prior written approval of the awarding agency.

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, advertising for fundraising purposes, endowment drives, solicitation of gifts and bequests, and similar expenses incurred solely to raise capital or obtain contributions are unallowable. Costs of grant writing, including personnel and grant reporting, are allowable.

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

These costs are allowable as direct costs to a sponsored award when necessary for the performance of the sponsored award and approved in writing by awarding agencies. Written documentation must be maintained to support such approval.

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

- They are necessary to meet fluctuations in workload; or
- 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 reasonable period of time, ordinarily not to exceed one year, depending on the initiative taken to use, lease, or dispose of such facilities; and
    - The idle facility capital cost does not exceed 10% of the facility's total capital cost. Capital costs are defined as facility depreciation, facility interest and or facility lease payments.

Interest: Costs incurred for interest on borrowed capital (i.e. loans, bonds, lines of credit, capital leases, etc.), temporary use of endowment funds, or the use of the non-profit organization's own funds, however represented, are unallowable.

Interest related to the construction or purchase of a facility is allowable unless the debt arrangement exceeds $1 million dollars and the initial equity contribution was less than 25%. This situation requires a calculation of cash flows to determine the amount that is unallowable. See 2 CFR 200.449 (c)(7)(ii) for more detail at http://www.ecfr.gov/cgi-

bin/text-idx?SID=700fa613fba6b28f8072084a0d76b3b4&node=se2.1.200_1449&rgn=div8

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

Lobbying: Lobbying costs 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.

Outreach: Costs incurred to perform outreach services into the general community are unallowable. Outreach activities targeted at a specific population of the CMHC (i.e. Medicaid or Indigent as defined by OBH) with the intent of making individuals aware of the services available and how to access them are allowable. Allowable outreach must be necessary to meet the requirements of the Federal award. An example of allowable outreach is a billboard that includes text such as "free to Medicaid members."

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 of Real Property and Equipment:
(a) Subject to the limitations described below, 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. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available.

(b) Rental costs under "sale and lease back" arrangements are allowable only up to the

amount that would be allowed had the non-Federal entity continued to own the property. This amount would include expenses such as depreciation, maintenance, taxes, and insurance.

(c) Rental costs under "less-than-arm's-length" leases are allowable only up to the amount as explained in paragraph (b) of this section. For this purpose, a less-than-arm's-length lease is one under which one party to the lease agreement is able to control or substantially influence the actions of the other.

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 economical and reasonable costs. Reimbursement may not exceed actual costs or per diem for staff members. Costs for official travel may not exceed the limits set by the Internal Revenue Service.

Recipients of Block Grant funds for Community Mental Health Services must follow the guidance in 2 CFR Part 200, Exhibit XI Section 4-93.958 (CFDA 93.958 Section III.A.):

A. Activities Allowed or Unallowed

1. Services provided with grant funds shall be provided only through appropriate, qualified community programs (which may include community mental health centers, child mental health programs, psychosocial rehabilitation programs, mental health peer support programs and mental health primary consumer-directed programs). Services under the plan will be provided through community mental health centers only if the services are provided as follows:

    a. Services principally to individuals residing in a defined geographic area (service area);

b. Outpatient services, including specialized outpatient services for children, the elderly, individuals with serious mental illness, and residents of the centers who have been discharged from inpatient treatment at a mental health facility;

c. 24-hours-a-day emergency care services;

d. Day treatment and other partial hospitalization services or psychosocial rehabilitation services; or

e. Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission (42 USC 300x-2(b) and (c)).

Recipients of Block Grant funds for Prevention and Treatment of Substance Abuse must follow the guidance in 2 CFR Part 200, Exhibit XI Section 4-93.959 (CFDA 93.959 Section III.A.):

A. Activities Allowed or Unallowed

1. The State shall not use grant funds to provide inpatient hospital services except when it is determined by a physician that (a) the primary diagnosis of the individual is SA and the physician certifies this fact; (b) the individual cannot be safely treated in a community based non-hospital, residential treatment program; (c) the service can reasonably be expected to improve an individual's condition or level of functioning; and (d) the hospital based SA program follows national standards of SA professional practice. Additionally, the daily rate of payment provided to the hospital for providing the services to the individual cannot exceed the comparable daily rate provided for community based non-hospital residential programs of treatment for SA and the grant may be expended for such services only to the extent that it is medically necessary (i.e., only for those days that the patient cannot be safely treated in a residential community based program) (42 USC 300x-31(a) and (b); 45 CFR sections 96.135(a)(1) and (c)).

2. Grant funds may be used for loans from a revolving loan fund for provision of housing in which individuals recovering from alcohol and drug abuse may reside in groups. Individual loans may not exceed $4,000 (45 CFR section 96.129).

3. Grant funds shall not be used to make cash payments to intended recipients of health services (42 USC 300x-31(a); 45 CFR section 96.135(a)(2)).

4. Grant funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment. The Secretary may provide a waiver of the

restriction for the construction of a new facility or rehabilitation of an existing facility, but not for land acquisition (42 USC 300x-31(a); 45 CFR sections 96.135(a)(3) and (d)).

5. The State shall not use grant funds to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funding (42 USC 300x-31(a); 45 CFR section 96.135(a)(4)).

6. Grant funds may not be used to provide financial assistance (i.e., a subgrant) to any entity other than a public or non-profit entity. A State is not precluded from entering into a procurement contract for services, since payments under such a contract are not financial assistance to the contractor (42 USC 300x-31(a); 45 CFR section 96.135 (a)(5)).

7. State shall not expend grant funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (42 USC 300ee-5; 45 CFR section 96.135 (a)(6) and Pub. L. No. 106-113, Section 505).

8. Grant funds may not be used to enforce State laws regarding sale of tobacco products to individuals under age of 18, except that grant funds may be expended from the primary prevention set-aside of SABG under 45 CFR section 96.124(b)(1) for carrying out the administrative aspects of the requirements such as the development of the sample design and the conducting of the inspections (45 CFR section 96.130 (j)).

9. No funds provided directly from SAMHSA or the relevant State or local government to organizations participating in applicable programs may be expended for inherently religious activities, such as worship, religious instruction, or proselytization (42 USC 300x-65 and 42 USC 290kk; 42 CFR section 54.4).

Standard 6: Reporting Period

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

These cost accounting standards guide the accounting of costs in the Annual Financial Statements (Exhibits A, B, C and D), the CMHC Colorado Unit Cost Report (Exhibit F), and the Fiscal and Statistical Supplementary Schedules for BHO's (Exhibit F). Please refer to Chapters 3 and 4 for specific instructions on completing these forms. Note that the Annual Financial Statements must reconcile to the CMHC Colorado Unit Cost Report or BHO Fiscal and Statistical Supplementary Schedules.

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 Entities. Notations are made here of any specific mental health service issues.

Community Mental Health Centers (CMHC)

Substantially all CMHCs will utilize the American Institute of Certified Public Accountants Guide for Health Care Entities. Certain exceptions to this may exist because they may qualify to use the AICPA Guide for Not-For-Profit Entities. 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 Exhibits A, B, C and D that provide greater detail into suggested financial statement reporting options. Which guide to use will require the judgment of the CMHC 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 (MSO)

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 controls.

Internal Controls

a) Consideration of the internal control system in a financial statement audit describes the elements of internal control and explains how an independent auditor should consider the internal control system in planning and performing an audit. An entity's internal control system 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 system, 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 system and the assessed level of control risk in determining the nature, timing and extent of substantive tests for financial statement assertions.

Expense Classifications and Allocation Methodologies

Expense categories will be required to be reported by natural classification on the statement of operations in the Annual Financial Statements. The expense categories required are more specific than generally accepted accounting principles and should agree to the Colorado Unit Cost Report totals as follows:

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

The following details what is to be included in each of the above totals:

Expense Description		Used for	Allocation Basis from Chapter 2, Standard 4: Method 1, 2 or 3
Personnel Costs			
	Salaries, Payroll Taxes and Employee Benefits	Salaries paid to regular employees, full or part-time, and temporary employees other than consultants and others engaged on an individual contract basis and the related taxes and costs of employee health insurance and retirement benefit plans.*	1, 2 or 3, based on the programs or cost centers where the services are provided
Client Related Costs			
	Client Salaries, Taxes and Benefits	Salaries paid to clients and related taxes and benefits	1 or 2
	External Doctors, Clinics and Hospitals	Amounts paid to external doctors, clinics and hospitals for services to clients	1
	Client Food	Cost of food provided to clients	1
	Medical Supplies and Laboratory	Cost of medical supplies and laboratory fees	1
	Medications	Cost of medications used by clients	1

Expense Description		Used for	Allocation Basis from Chapter 2, Standard 4: Method 1, 2 or 3
	Purchases from Other Providers	Expenses for purchasing services from other providers that provide the same or similar services	1
	Supplies and Travel	Cost of supplies used by clients (i.e. recreation and craft materials) and the cost of transporting clients to and from programs	1
Occupancy Costs			
	Janitorial	Expenses resulting from an agency's occupancy and use of owned, rented, leased or donated building and offices	1 or 2
	Maintenance and Supplies		
	Property Insurance		
	Rent		
	Real Estate Taxes		
	Utilities		
Operating Costs			
	Dues, Fees, Licenses and Subscriptions	Costs of memberships in other organizations, publications, bank and collection fees, licenses, etc.	1
	Equipment Rentals and Maintenance	Costs of renting or leasing and maintaining equipment such as computers, office equipment and program equipment	1 or 2
	Insurance	Costs, paid or accrued, of premiums for insurance contracts to reimburse the organization 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)	1, 2 or 3, based on what the insurance covers
	Interest	Costs of borrowing money (subject to restrictions noted in Standard 5: Unallowable Costs)	1, 2 or 3, based on the use of the borrowed funds
	Office Supplies	Costs of office supplies and low cost furniture and equipment that is not capitalized	1 or 2

Expense Description		Used for	Allocation Basis from Chapter 2, Standard 4: Method 1, 2 or 3
	Postage, Printing and Copying Costs	Costs of postage, internal and external printing and copying costs for such items as brochures, manuals and pictures	1 or 2
	Telephone	Costs of telephone and other electronic communication expenses	1 or 2
	Travel, Conferences and Staff Development	Expenses of staff travel including mileage allowances, hotel, meals and incidental expenses and expenses associated with providing formal internal and external staff development programs including training classes, meeting space and equipment rentals	1 or 2
	Automobile Expenses	Costs of agency-owned or leased vehicles	1 or 2
Depreciation and Amortization		Depreciation and amortization expense for depreciable assets owned by the agency	1 or 2
Provision for Uncollectible Accounts		Amount of estimated uncollectible portions of accounts receivable **	1 or 2
Professional Fees		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	1 or 2
Donations (Donated In-Kind or Cash)		Value of donations made to other organizations or received from other organizations for cash, material and building space, volunteer services, hospital care, and donated psychiatric medications	1 or 2

* When federal funds are used, executive salary caps are in effect, and the amount in excess of the cap is an unallowed expense. For further guidance, see https://grants.nih.gov/grants/guide/notice-

files/NOT-OD-17-087.html.

** 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's 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.

General 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 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 Audit and Accounting Guide, Health Care Entities, as well as the requirements contained elsewhere in this guide.

OBH and HCPF require that the independent auditor of the CMHCs' 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 2 CFR 200, 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 2 CFR 200 Subpart F 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 Statement Auditing Guidelines

The annual audited financial statements are the primary documents used to calculate the organization's service cost. The audits of these financial statements provide credibility to the reimbursement system presented to the legislature, as financial statement information is subjected to independent audit procedures including testing of controls and the validity of supporting documentation. Required financial statements are presented in Exhibits A, B, C and

D; however, if changes are made to the AICPA Audit and Accounting Guide, Health Care Entities, conforming changes must be made to the financial statement presentation.

For CMHCs, all transactions with related parties (i.e., Parent Company/Management Fees, lease expenses, etc.) must be disclosed in a report of Related Party Transactions (Exhibit G). If no fair market value (FMV) is readily available for a related party transaction, this must be noted on the schedule.

Management Letter

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

OBH and HCPF require copies of SAS 115 communications and management letters 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 2 CFR 200 Subpart F are appropriately included in the applicable report.

BHO Only: Third-Party Liability Reporting

For services reported in any encounter data submission, including units of service reported on Schedules 3 and 3A of the CMHC Colorado Unit Cost Report (see Chapter 4 for more details), where the encounter record had a service date between 7/1/2017 and 6/30/2018, 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 H of the Appendix. Only BHOs need to complete Exhibit H. 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 H 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 20XX	
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.

BHO Only: 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 costs reported are 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 CFR 438-600 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.

BHO Only: Fiscal and Statistical Supplementary Schedules and Agreed Upon Procedures

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 F 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 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 of 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 costs 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 Colorado Unit Cost Report

In addition to completing annual financial statements (Exhibits A, B, C and D), the CMHCs must also complete a Colorado Unit Cost Report (Exhibit F) that requires detailed reporting of expenses and utilization. These schedules capture the data necessary to calculate the base unit cost for each CMHC which is used in the RVU pricing methodology.

Schedule 1: Trial Balance of Expenses

Trial Balance of Expenses by Functional Classification

As described in Chapter 2, Standards 2 through 4, the provider will perform an expense classification process to separate expenditures into functional cost centers and/or programs. This functional classification will be used to summarize items of costs for each CMHC and allow for assignment or allocation of costs to the appropriate functional columns on the Colorado Unit Cost Report. Proper allocation across columns may involve splitting the costs of some cost centers and/or programs across multiple columns based on the services provided by these cost centers and/or programs (i.e. encounter-based vs. non-encounter-based). Providers must maintain and make available supporting documentation of their allocation methodologies. The functional columns defined on Schedule 1 of the Colorado Unit Cost Report are as follows:

Column 1- Full Time Equivalents (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 Centers and/or Programs):
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 and/or program will be reported discretely in this column and allocated out to columns 3 through 8.

Column 3 – Non-Integration Encounter-based Services with RVU Weights:
For costs related to the provision of outpatient services that are not integrated with physical healthcare services which generate encounters with approved CPT/HCPCS billing codes and have established RVU weights assigned to them. Column 3 should not include costs of any RVU services that are provided in an inpatient hospital setting. These should be included in Column 5 (Inpatient Hospital Services).

Column 3a – Integration Encounter-based Services* with RVU Weights:
For costs related to the provision of outpatient services that are integrated with physical

healthcare services which generate encounters with approved CPT/HCPCS billing codes and have established RVU weights assigned to them.

Column 3b –Integration Services* without RVU weights:
For costs related to the provision of outpatient services that are integrated with physical healthcare services which do not meet the criteria of Column 3a. Costs of providing primary care services in an integrated setting that are included in this column must be offset by payments received for those primary care services.

***Integration services** are those that benefit the whole person and involve the integration and/or coordination of a spectrum of behavioral health and physical health services to improve the health of the patient. Costs of services *in Levels 3 through 6* of the integration levels below should be included in Columns 3a or 3b as appropriate (from *A Standard Framework for Levels of Integrated Healthcare by SAMHSA-HRSA Center for Integrated Health Solutions, April 2013*):

Level 1 — Minimal Collaboration: Behavioral health and primary care providers work at separate facilities and have separate systems. Providers communicate rarely about cases. When communication occurs, it is usually based on a particular provider's need for specific information about a mutual patient.

Level 2 — Basic Collaboration at a Distance: Behavioral health and primary care providers maintain separate facilities and separate systems. Providers view each other as resources and communicate periodically about shared patients. These communications are typically driven by specific issues. For example, a primary care physician may request copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis. Behavioral health is most often viewed as specialty care.

Level 3 — Basic Collaboration Onsite or Via Technology-Based Services: Behavioral health and primary care providers co-located in the same facility or both provide services to shared patients via technology-based services (text, email, apps or telehealth), but may or may not share the same practice space. Providers still use separate systems, but communication becomes more regular due to close proximity, especially by phone or email, with an occasional meeting to discuss shared patients. Movement of patients between practices is most often through a referral process that has a higher likelihood of success because the practices are in the same location or share technology-based services. Providers may feel like they are part of a larger team, but the team and how it operates are not clearly defined, leaving most decisions about patient care to be done independently by individual providers.

Level 4 — Close Collaboration with Some System Integration: There is closer collaboration among primary care and behavioral healthcare providers due to colocation in the same practice space or shared technology-based services, and there is the beginning of integration in care through some shared systems. A typical model may involve a primary care setting embedding a behavioral health provider. In an embedded practice, the primary care front desk schedules all appointments and the behavioral health provider

has access and enters notes in the medical record. Often, complex patients with multiple healthcare issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

Level 5 — Close Collaboration Approaching an Integrated Practice: There are high levels of collaboration and integration between behavioral and primary care providers. The providers begin to function as a true team, with frequent personal communication. The team actively seeks system solutions as they recognize barriers to care integration for a broader range of patients. However, some issues, like the availability of an integrated medical record, may not be readily resolved. Providers understand the different roles team members need to play and they have started to change their practice and the structure of care to better achieve patient goals.

Level 6 — Full Collaboration in a Transformed/Merged Practice: The highest level of integration involves the greatest amount of practice change. Fuller collaboration between providers has allowed antecedent system cultures (whether from two separate systems or from one evolving system) to blur into a single transformed or merged practice. Providers and patients view the operation as a single health system treating the whole person. The principle of treating the whole person is applied to all patients, not just targeted groups.

Column 4 - Encounter-based Services at ATU's and CSU's:
For costs of providing encounter-based services without RVU weights in an ATU or CSU, including labs and medications.

The costs of providing encounter-based services with RVU weights in an ATU such as professional services in an inpatient setting (therapy, medication management, evaluations, etc.) are to be classified under Column 3, Encounter-based Services with RVU Weights, noted above.

Column 5 – Inpatient Hospital Services:
For all costs of providing inpatient services with and without RVU weights in a hospital setting, including labs and medications.

Column 6 - Encounter-based Residential Services without RVU Weights:
For costs related to the provision of residential services in a 24 hour 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, medication

management, evaluations, etc.) are to be classified under Column 3, Encounter-based Services with RVU Weights.

Column 7 - Non-encounter-based services and encounter-based other services without RVU weights:

For costs of encounter-based services that do not have established RVU weights assigned to them such as OBH Early Childhood direct services, some capacity-funded programs, pharmacy encounters, emergency encounters (without RVU weights) and lab encounters not included in Column 4 - Encounter-based Services at ATU's and CSU's or Column 5 - Inpatient Hospital Services.

For costs of programs that do not generate encounters such as costs of some capacity-funded programs, housing services, or other non-encounter-based services that are unfunded or funded by outside grantors.

For direct costs of contracted lab services and pharmaceuticals such as psychiatric medications (including injectable medications) not included in Column 4 - Encounter-based Services at ATU's and CSU's or Column 5 - Inpatient Hospital Services.

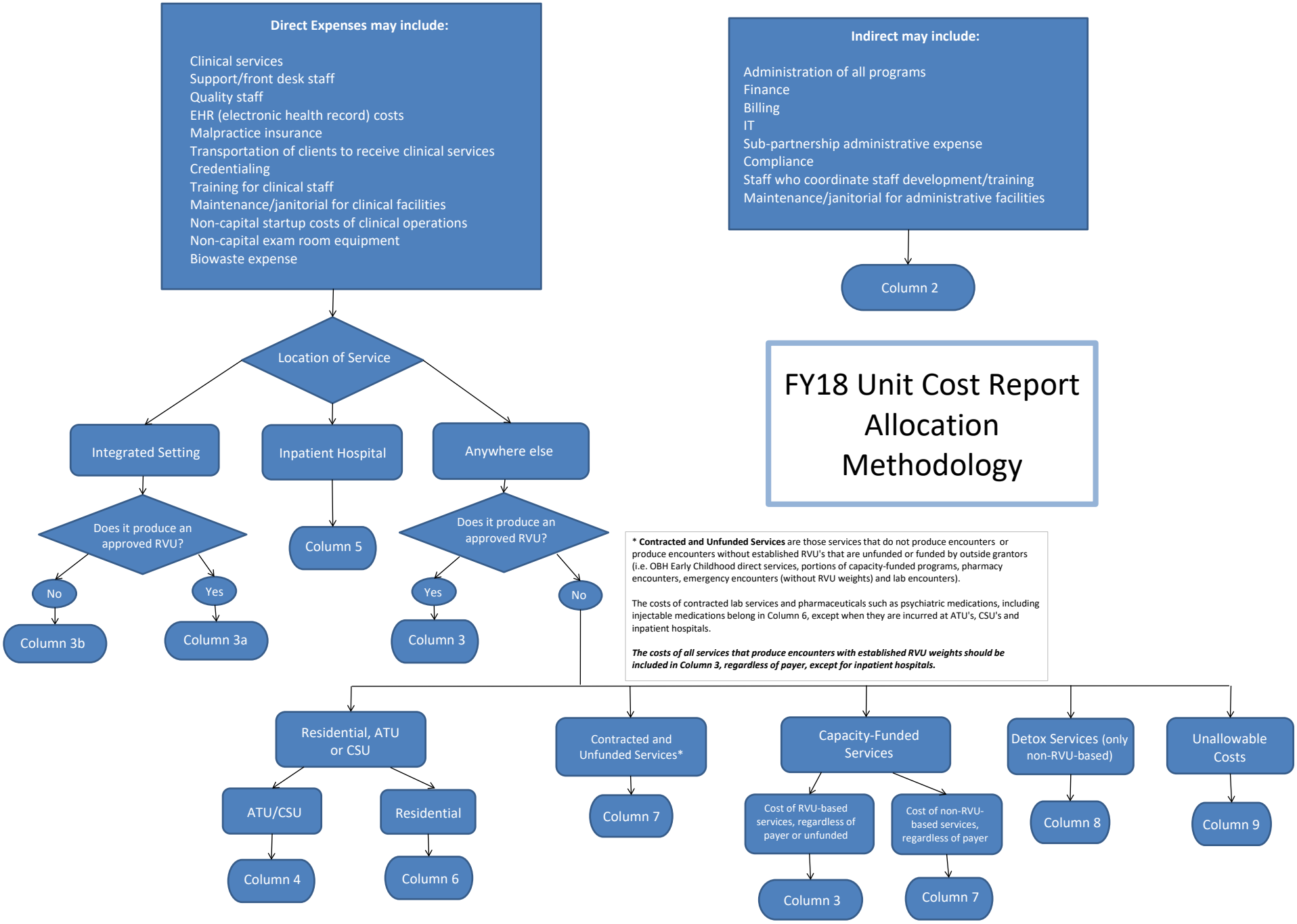
Note: The costs of encounter-based services with established RVU weights that are paid for by capacity-funded programs (i.e. RVU-based services provided to a client that is 'self-pay' or has a third party payer but for which the CMHC was not reimbursed) or any other payer should be included in Column 3, Encounter-based Services with RVU Weights.

Column 8 – Detox Services without RVU weights:

For costs related to the provision of detox services that generate encounters without RVU weights and that do not generate encounters.

Column 9 - Unallowable costs:

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


Direct Expenses may include:
Clinical services
Support/front desk staff
Quality staff
EHR (electronic health record) costs
Malpractice insurance
Transportation of clients to receive clinical services
Credentialing
Training for clinical staff
Maintenance/janitorial for clinical facilities
Non-capital startup costs of clinical operations
Non-capital exam room equipment
Biowaste expense
Indirect may include:
Administration of all programs
Finance
Billing
IT
Sub-partnership administrative expense
Compliance
Staff who coordinate staff development/training
Maintenance/janitorial for administrative facilities
Column 2
Location of Service
Integrated Setting
Inpatient Hospital
Anywhere else
Does it produce an approved RVU?
Column 5
Does it produce an approved RVU?
No
Yes
Yes
No
Column 3b
Column 3a
Column 3
FY18 Unit Cost Report Allocation Methodology
* Contracted and Unfunded Services are those services that do not produce encounters or produce encounters without established RVU's that are unfunded or funded by outside grantors (i.e. OBH Early Childhood direct services, portions of capacity-funded programs, pharmacy encounters, emergency encounters (without RVU weights) and lab encounters).
The costs of contracted lab services and pharmaceuticals such as psychiatric medications, including injectable medications belong in Column 6, except when they are incurred at ATU's, CSU's and inpatient hospitals.
The costs of all services that produce encounters with established RVU weights should be included in Column 3, regardless of payer, except for inpatient hospitals.
Residential, ATU or CSU
Contracted and Unfunded Services*
Capacity-Funded Services
Detox Services (only non-RVU-based)
Unallowable Costs
ATU/CSU
Residential
Column 7
Cost of RVU-based services, regardless of payer or unfunded
Cost of non-RVU-based services, regardless of payer
Column 8
Column 9
Column 4
Column 6
Column 3
Column 7

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 column descriptions cannot be changed or modified by the provider.

Line 1 – Total Direct Program Staff FTE and Salaries:

Line 1, column 1: all direct program staff full-time equivalents (FTEs). An FTE is based on annual number of hours worked (2,080 hours).

Line 1, columns 3 through 9: salaries, wages, and other non-fringe compensation for the direct care program staff incurred by each functional cost center and/or program.

Line 2 – Total Administrative Staff FTE and Salaries:

Line 2, column 1: all administrative staff FTE's who are not directly assignable to a cost center and/or program. An FTE is based on annual number of hours worked (2,080 hours).

Line 2, column 2: salaries, wages and other non-fringe compensation for all administrative staff who are not directly assignable to a cost center and/or program.

Note: The total FTE's for Direct Program Staff + Administrative Staff = the total organization's FTE's as of June 30, 20XX.

Line 3 – Total Personnel

Line 3 automatically calculates the Total Personnel in columns 2 through 9; there is no data entry on this line.

Lines 4 – 10 – Natural Classification of Expenses:

Lines 4 through 10, columns 2 through 9 will contain all non-compensation expenses by natural classification.

- Providers should report costs which cannot be allocated directly to a direct service cost center and/or program (indirect expenses only) in column 2 by the appropriate line definition. (See Chapter 4 for definitions).
- For column 9, Unallowable Costs, these costs are accumulated by natural classification (See Chapter 4 for definitions).
- For columns 3 through 8, the provider should report all costs that are charged or allocated directly to the direct service cost centers and/or programs that have not been recorded in columns 2 or 9. The costs should

be classified by the appropriate line definition.

NOTE: The Natural Classification definitions (lines 1 through 10) and specific expense item roll ups are detailed in Chapter 3.

Line 11, columns 2 through 10 – Total Direct Expenses:

Line 11, columns 2 through 10 calculate automatically. No data entry required.

Line 12 – Indirect Cost Allocation:

Line 12, column 2 is the amount of indirect cost to be allocated to the functional cost centers and/or programs to obtain full functional program cost. It is the negative of the total expenses for column 2, line 11.

Cost allocation for line 12, across columns 3 through 9, must be based on sound and reasonable methodologies for allocation. Indirect costs must be allocated to all columns, including column 9, Unallowable Costs, and all items of cost included in column 7, Non-Encounter-based Costs and Encounter-based Other Services Without RVU Weights, such as labs and medications. This line will total to $0 in column 10 as it is an allocation to offset the amount in line 12, column 2.

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

Line 13 – Total Cost:

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

Note: Line 1 and Lines 3 through 11 (across columns 2 through 9), as summed in column 10 (Total Cost), should agree to the natural expense classification line items in the expenses shown on the CMHC's Statement of Operations in the organization's audited financial statements. *Column 10 is a summation column (cross totaling columns 2 through 9), no data entry required.*

Line 14 – Unduplicated Client Count:

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

Providers are to report the total number of clients served by cost center and/or program. Client counts may be duplicated by cost center and/or program. This calculation is not applicable for column 4 (Encounter Based Services *without* RVU Weights at ATU's and CSU's), column 5 (All Inpatient Hospital Services) and column 7 (Encounter Based Other Services *without* RVU weights and Non-Encounter Based Costs).

Line 15 – Cost per Unduplicated Client

Cost per Unduplicated Client is an automatically calculated field (Total Cost divided by Unduplicated Client Count). This calculation is not applicable for column 4 (Encounter Based Services *without* RVU Weights at ATU's and CSU's), column 5 (All Inpatient Hospital Services) and column 7 (Encounter Based Other Services *without* RVU weights and Non-Encounter Based Costs).

Schedule 2: Supplemental Schedule for Column 7

Section I: List each individual expense that is greater than or equal to $50,000 that was included in Column 7 of Schedule 1.

Section II: Total of all expenses that individually were less than $50,000 that were included in Column 7 on Schedule 1.

Schedule 2A: Supplemental Schedule for Column 8 (Detox)

Section I: The number of units provided for each procedure code listed is automatically pulled from Schedules 3 and 3A. Enter the total cost of providing these services. These costs are a subset of the costs included in Schedule 1, Column 3. Total cost should include an appropriate administrative allocation.

Section II: List each individual expense for non-encounterable services not included in Section I that is greater than or equal to $50,000 that was included in Column 8 on Schedule 1.

Section III: Total of all expenses that individually were less than $50,000 that were included in Column 8 on Schedule 1.

Schedule 2B: Supplemental Schedule for Column 3b (Integration Services)

Section I: Complete the number of units provided for each procedure code listed. Enter the total cost of providing these services. Total cost should include an appropriate administrative allocation.

Section II: List each individual expense not included in Section I that is greater than or equal to $50,000 that was included in Column 3b on Schedule 1.

Section III: Total of all expenses that were individually less than $50,000 that were included in Column 3b on Schedule 1.

Payments from all payer sources for primary care services provided by integrated clinics owned by CMHC's, the cost of which are included on Schedule 1, Column 3b, are to be reported as a third party liability offset on this schedule.

Schedule 2C: Base Unit Cost Calculation for Non-RVU Substance Abuse Codes

Enter the total cost of providing each subset of services listed. The total cost should include the same level of administrative overhead as that used in Schedule 1 Column 3.

Total units are automatically calculated from Schedules 3 and 3A. No entry is required.

Schedule 3: Utilization (Encounter-based Services with Non-Facility RVU Weights)

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

Units of service reported on Schedule 3 should only be related to the costs reported on Schedule 1, from Column 3, Encounter-Based Services with RVU Weights, and the costs of encounter-based donated services with RVU weights.

In order to complete Schedule 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. Place of service (POS) code
    d. Date of Service
    e. Number of Units

From the service encounter data, providers must 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

Providers should report all *encounterable units of service, with or without an RVU weight*, provided in a Non-Facility setting by the CPT/HCPCS codes listed on Schedule 3. Service definitions for the CPT/HCPCS codes are in the column labeled "Description." Units reported must be of the same nature and time period as defined in this column. The Total line automatically calculates the total units. The provider should not enter any data in this line.

Column 2- Total Relative Value Units

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.

Schedule 3A: Utilization (Encounter-based Services with Facility RVU Weights)

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

Units of service reported on Schedule 3A should only be related to the costs reported on Schedule 1, Column 3, Encounter-based Services with RVU Weights, and the costs of encounter-based donated services with RVU weights.

In order to complete Schedule 3A, 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. Place of service (POS) code
    d. Date of Service
    e. Number of Units

From the service encounter database, providers must 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

Providers should report all *encounterable units of service, with or without an RVU weight*, provided in a Facility setting by the CPT/HCPCS codes listed on Schedule 3A. Service definitions for the CPT/HCPCS codes are in the column labeled "Description." Units reported must be of the same nature and time period as defined in this column. The Total line automatically calculates the total units. The provider should not enter any data in this line.

Column 2- Total Relative Value Units

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.

Schedule 4: Base Unit Cost Calculation

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

At the top of Schedule 4, the Total Allowable Cost for Encounter-Based Services is pulled in from Schedule 1, Columns 3, 3a and 3b, Line 13. The Total Relative Value Units are pulled in from Schedule 3, Column 2, Total line and Schedule 3A, Column 2, Total line. The Base Unit Cost is automatically calculated by dividing the Total Allowable Cost for Encounter-Based Services by the Total Relative Value Units.

Column 1 – 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 – 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.

DESCRIPTION OF SIGNIFICANT CHANGES IN BASE UNIT COST YEAR OVER YEAR

If the Base Unit Cost from Schedule 4 increased or decreased by 5% or more over the previous fiscal year, an explanation of the reasons for the change are required in a separate document. This may include the reasons for changes in Administrative and/or Direct Costs from Schedule 1 as well as changes in units of service from Schedules 3 and 3A.

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, CSU, Inpatient and Detox).

Column 3-License Type:

Indicate what license each facility is registered under.

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 6 automatically calculates the utilization rate by dividing the census days by the bed capacity for each facility. The provider should not enter any data in Column 6.

Column 7-Total Expenses:
The total expenses per residential/inpatient facility should be entered in Column 7. The total expenses in column 7 should agree to the total of Schedule 1, Columns 4, 5, 6 and 8 and Section I of Schedule 2A.

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

Exhibit A: CMHC Example Financial Statements

The following is a model financial statement following the AICPA Audit and Accounting Guide, Health Care Entities; however the appropriate audit guide should be followed. A CMHC provider may be awarded the Medicaid capitation contract in which case the CMHC 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 at http://emma.msrb.org/ or at the Electronic Data Gathering, Analysis, and Retrieval system (EDGAR) at https://www.sec.gov/edgar.shtml. 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 these examples.

CMHC

BALANCE SHEETS
JUNE 30, XXXX 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	_____	_____
	$_____	$_____

CMHC

BALANCE SHEETS
JUNE 30, XXXX XXXX

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

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

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

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 Audit and Accounting Guide, Health Care Entities. In addition to those footnote disclosures that fulfill the accounting profession's reporting standards of adequate disclosure, the Office of Behavioral Health 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 Audit and Accounting Guide, Health Care Entities.

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

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

5. Charity care.

Financial Statement Supplemental Schedule:
CMHC

SUPPLEMENTARY SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXXX

REVENUES

Client service:
- Medicaid capitation
- Medicaid Hospital Alternatives
- Medicaid fee for service
- OBRA
- 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 Behavioral Health
  - Division of Youth Services
- Total Colorado Dept. of Human Services
- 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 directed to the example financial statements 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 https://www.sec.gov/edgar.shtml. 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 these examples.

BHO

BALANCE SHEETS
JUNE 30, XXX2 AND XXX1

ASSETS	XXX2	XXX1
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 $_____ XXX2, $_____ XXX1		
LIABILITIES AND NET ASSETS		
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, XXX2 AND XXX1

	XXX2	XXX1
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, XXX2 AND XXX1

	XXX2	XXX1
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 AICPA Audit and Accounting Guide, Health Care Entities 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 Statements

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 these 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 Activities – 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 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 - Statement of Activities – 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 formats for the statement of changes in net assets-a single column and a multicolumn- are illustrated. The two statement approaches of Format C focus attention on changes in unrestricted net assets. That format may be preferred by not-for-profit's 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 - Statement of Activities – 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 - Statement of Activities – 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: Managed Service Organization Example Financial Statements

MANAGED 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 Audit and Accounting Guide, Health Care Entities. In addition to those footnote disclosures that fulfill the accounting profession's reporting standards of adequate disclosure, the Office of Behavioral Health 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 AICPA Audit and Accounting Guide, Health Care Entities.

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

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

	Outpatient & Residential	Addl Family	General & Admin	
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 E: Sub-Recipient of MSO Supplemental Schedules

SUB-RECIPIENT OF MSO
SUPPLEMENTARY SCHEDULE OF 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	Program	General and Admin	Total
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					

Exhibit F: Colorado Unit Cost Report Template and Fiscal & Statistical Indicators Spreadsheet

https://www.colorado.gov/pacific/hcpf/mental-health-rate-reform-0

Exhibit G: 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
1			$	$
2			$	$
3			$	$
4			$	$
5			$	$
6			$	$
7			$	$
8			$	$
9			$	$
10			$	$
11			$	$
12			$	$
13			$	$
14			$	$
15			$	$
	TOTAL		**$**	**$**

Exhibit H: 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 I: 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.

Accountable Care Collaborative – A program designed to affordably optimize Member health, functioning, and self-sufficiency. The primary goals of the Program are to improve Member health and life outcomes and to use state resources wisely. Regional Accountable Entities (RAEs) and Primary Care Medical Providers (PCMPs) that serve as medical homes work together in collaboration with other health providers and Members to optimize the delivery of outcomes-based, cost-effective health care services.

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.

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

Clinical Database - 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.

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.

Primary Care Medical Provider (PCMP) – A primary care provider contracted with a BHO to participate in the Accountable Care Collaborative as a Network Provider.

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).

Regional Accountable Entity (RAE) – A single regional entity responsible for the duties previously performed by Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs).

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. Utilization Review is frequently used to curtail the provision of inappropriate services and/or to ensure that services are provided in the most cost-effective manner.