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MENTAL HEALTH ACCOUNTING AND AUDITING GUIDELINES

Department of Health Care Policy and Financing
1570 Grant St.
Denver, CO 80203
303-866-2993
303-866-4411 - Fax

Division of Behavioral Health
3824 W. Princeton Circle
Denver, Colorado 80236
Fax
303-866-7400
303-866-7428 – Fax

Prepared By:

PUBLIC CONSULTING GROUP

148 State St, 10th Floor
Boston, MA 02109
617-426-4026
617-426-4632 -

www.pcgus.com

Table of Contents

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

CHAPTER 1

OVERVIEW

CHAPTER 1: OVERVIEW

PURPOSE

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

1. To provide guidelines for recording and reporting revenues and expenses of Colorado's mental health services delivery system. They are intended to be:
   - responsive to the informational needs of Colorado's mental health system,
   - sensitive to constraints and limitations on accounting for and reporting on revenues and expenses within the mental health system, and
   - incorporative of generally accepted accounting principles and auditing standards and procedures.

2. A comprehensive cost reporting system for Colorado's community mental health centers, clinics, and Behavioral Health Organizations (BHOs) that:
   - defines types of cost and basic cost-accounting standards,
   - captures cost data for services provided by the centers and clinics
   - captures utilization for those services with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes and Relative Value Unit (RVU) weights
   - calculates a base cost per RVU unique to each center or clinic

BACKGROUND

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

This disparity in unit costs could have been the result of genuine differences in the resources used in providing the services. But the differences in estimates may have been attributed to variations in cost accumulation and allocation procedures and to variations in accumulating operating statistics used in determining the unit costs of services. If the wide variations were attributable to accounting and statistical variations, in whole or in part, and not to real differences in resource consumption, allocation of state funds could not be either accurate or equitable.

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

> . . . the Division of Mental Health, Department of Institutions, (name is now Division of Behavioral Health, Department of Human Services) with the assistance of the Colorado Association of Community Mental Health Centers and Clinics, (name is now The Colorado Behavioral Healthcare Council) undertake an intensive study by management and accounting experts of the cost-finding, cost accounting and unit-cost calculations, approaches, and techniques to be employed by centers and clinics.
>
> . . . that the end product of this intensive study by management and accounting experts be a recommended set of standards, operating procedures and accounting procedures for centers and clinics to be implemented in successive steps starting with the FY 1977-78 budget request.

DEVELOPMENT OF THE GUIDELINES

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

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

The committee members that participated in the June 30, 2003 revisions are:

Steve Cordova, Southeast Mental Health Services
Mike Crane, DHS, MHS
Neal Christensen, CPA, DHS, OPI, Audit Division

Phil Debus, CPA
Millie DeSmet, CPA, Jefferson Center for Mental Health
John Golden, CPA, Pikes Peak Mental Health Systems
Tina McCrory, Colorado Health Networks
Kimberly McKay, CPA, BKD
Cynthia Nelson, CPA, Mental Health Corporation of Denver

In February, 2009, HCPF hired Public Consulting Group, Inc. (PCG) to help update the guidelines and to combine the two different versions used by DBH and HCPF into one set of guidelines. Additionally, PCG, with the input of mental health stakeholders, redesigned the reporting of costs by the Community Mental Health Centers to allow HCPF to move from a unit pricing methodology to the development of a Relative Value Unit (RVU) pricing schedule, as recommended in the Medicaid Mental Health Performance Audit for November 2006 (Mercer Audit) regarding accounting methodology for encounter pricing.

The committee members who participated in the 2009 revision of the guidelines are as follows:

Steve Cordova, Southeast Mental Health Services
Tina McCrory, Colorado Health Networks
Kimberly McKay, CPA, BKD
John Rattle, Northeast Behavioral Health
Rian Nowitski, BHI
Don Rice, CBHC
Dawn Romero, Southeast Mental Health Services
Wes Law, Community Reach Center
Brad Wilcox, San Luis Valley Mental Health Center
Carol Lipkowski, Community Reach Center
Andrew Martinez, DBH
Randall Deyle, DBH
Sharon Liu, HCPF
Sarah Campbell, HCPF
Jed Ziegenhagen, HCPF

APPLICABILITY

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

UPDATING THE GUIDELINES

A committee needs to be established to convene on an annual basis to evaluate the guidelines for their applicability to the present circumstances and recommend changes. The committee will consist of representatives from HCPF, DBH, the BHOs, and the CMHCs. Any changes needed to the guidelines must be agreed upon and implemented by April 30 for implementation in the new fiscal year. DBH and HCPF as the granting making and funding entities will have the final authority in approving updates to the guidelines to ensure compliance with state and federal regulations.

CHAPTER 2

COST ACCOUNTING STANDARDS

CHAPTER 2: COST-ACCOUNTING STANDARDS

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

Standard #1. Costs are to be estimated, accumulated and reported on a consistent basis.

Consistency is required in classification of costs as a direct or indirect costs and the method used in allocating indirect costs to direct cost centers.

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

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

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

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

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

A Statement of Functional Expenses shows the major types of expenses for each functional expense program category. Program categories are presented in columns and the natural expense classifications are presented in rows. The functional reporting classifications are dependant upon the type of services rendered by the organization. The functional expense classification will be used by providers to report costs by direct cost centers in the Supplemental Cost Report (Exhibit

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

Total expenses categorized under the Natural classification in the annual financial statements must reconcile to functional classification on the Supplemental Cost Report.

Standard 3. Items of cost incurred by the Providers should be classified consistently. To establish this consistency, the following definitions of 'direct costs' and 'indirect costs' should be used when classifying items of cost[1]:

Direct costs are items of costs that are directly assignable to a cost center. In general, costs should be treated as direct to cost centers when they are incurred in support of a specific program or cost center. This includes both direct service costs, such as salaries and wages for direct service staff, and administrative and operating costs that can be directly attributable to a certain program or service. See the Example 1 in the box to the right for examples of these two types of direct costs. Direct identification of specific expenses (also referred to as *assigning expenses*) is the preferred method of charging expenses to various functions. If an expense can be specifically identified with a program or supporting service, it should be assigned to that function (direct costs). For example, travel costs incurred in connection with a specific program activity should be assigned to that program. Salaries of those who perform more than one type of service and certain administrative and fund-raising activities that can be specifically identified with a function should charged to those functions. For example, the portion of salaries and expenses that are related to the direct supervision of a program or specific fund-raising activity rather than the overall organization as a whole should be treated as direct costs. If direct identification (that is, assignment) is impossible or impracticable, costs should be treated as indirect and an allocation is appropriate.

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

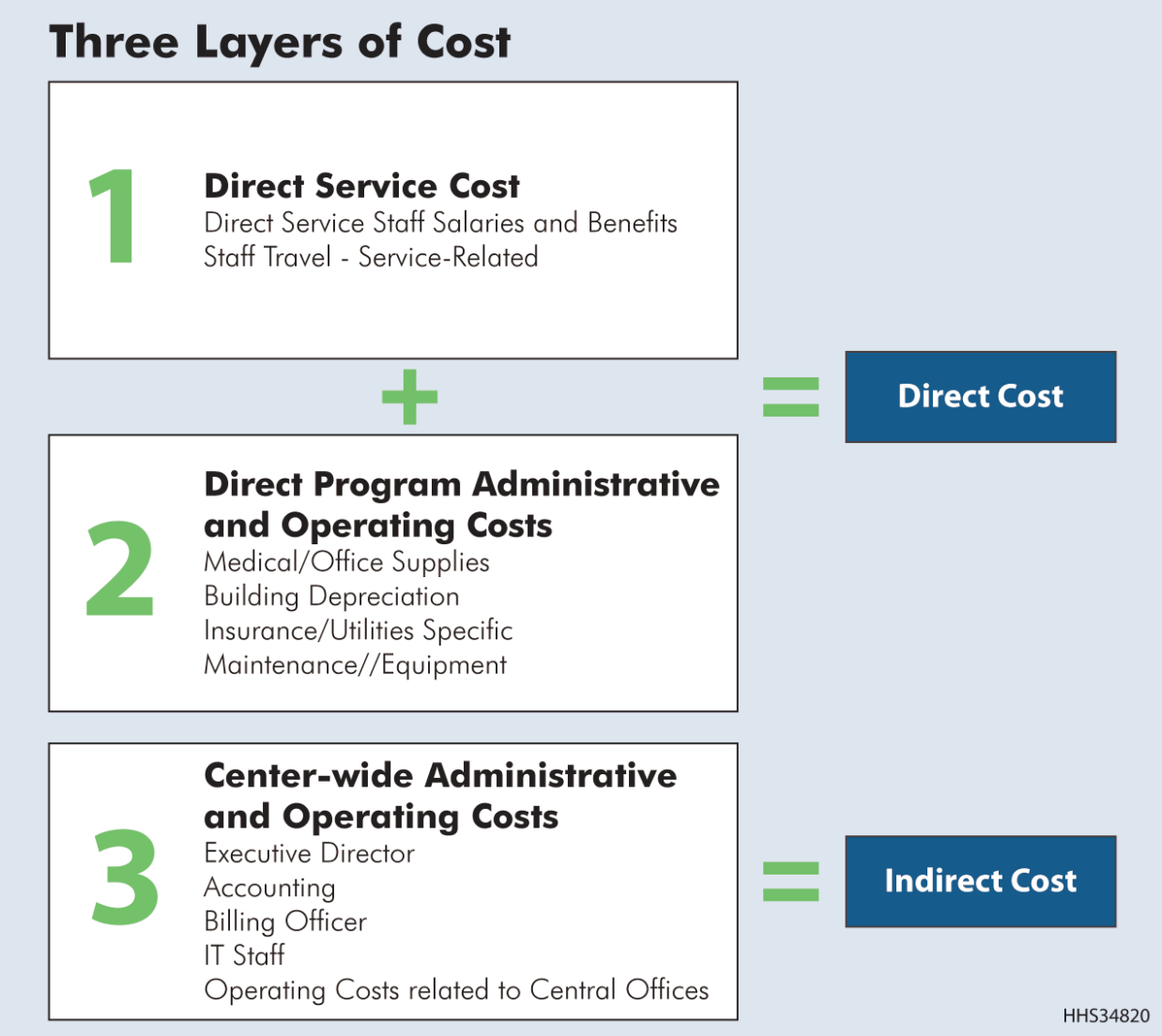
A ***direct administrative or operating cost*** might be the expense of medical supplies for a patient program. Since this cost is incurred in support of a specific program, rather than benefitting the facility as a whole, this cost would be treated as a direct cost and assigned to the cost center appropriate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

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

Indirect costs include items of costs that are not easily assignable to a specific cost center and are incurred by the provider for a common purpose benefiting the facility as a whole. These indirect costs will be allocated to the cost centers using a multiple-base step down methodology. See Standard 4 below for an explanation of assigning and allocating items of cost. Costs that are incurred in support of all program and service areas across the entire operation of a Center should be treated as indirect costs. Certain administrative operations, such as the Executive Director's office or Accounting department, are necessary for the proper functioning of a Center. Since they support all program areas, they are considered indirect costs and should be statistically allocated to the cost centers. In some situations, one item of cost may be partly assignable to a cost center, and partly treated as an indirect cost. See Example 2 in the box to the right for an example of one such item of cost and how to treat it appropriately.

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

The following chart illustrates the three layers of cost:



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

Certain items of cost are unallowable for reimbursement by HCPF and DBH or only allowable in certain situations. Definitions of certain items of cost, both those that are wholly non-allowable and those that are unallowable in certain situations, are as follows:

Advertising and Public Relations Costs[2].

Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily used for the benefit of public health programs.

Allowable Advertising Costs

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset.

Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in "bond expenses" and prorated over the life of the bonds.

Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

Unallowable Advertising Costs

[2] Department of Health & Human Services, Centers for Medicare & Medicaid Services, The Provider Reimbursement Manual, Part 1. Chapter 21, Costs Related to Patient Care, October, 2004

Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

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

Alcoholic Beverages. The cost of alcoholic beverages is never allowable.

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

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

Contributions and Donations. Contributions and donations, including cash, property, and services, others, 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 of the governmental unit followed for the individual items or classes of assets involved. The asset will depreciate much faster earlier in its life than in the later part.

Under GAAP, a plant or equipment asset can be depreciated using one of four basic methods:
The straight-line (SL) method**:** The asset is depreciated by dividing the depreciable base (acquisitions cost – residual value) by the number of years in the estimated life to determine each year’s depreciation expense. Thus, under SL, each year’s depreciation expense is the same.

The units of production (UOP) or units of output method: The asset is depreciated each year according to the number of units produced, total hours used, total miles driven, or other measure of production. Thus, under UOP, the amount of annual depreciation fluctuates by output or use.

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.

The computation of depreciation or use allowances will exclude: (1) The cost of land; (2) Any portion of the cost of buildings and equipment borne by 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.

Entertainment Costs. Costs of amusement, diversion, social activities, ceremonials, and costs relating thereto, such as meals, lodging, rentals, transportation, and gratuities are unallowable. Entertainment costs for official functions such as open houses to acquaint the community with center services are allowable.

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

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

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

Housing and Personal Living Expenses.

a. Costs of housing (e.g., depreciation, maintenance, utilities, furnishings, rent, etc.), housing allowances and personal living expenses for/of the organization's officers are unallowable as fringe benefit or indirect costs regardless of whether the cost is reported as taxable income to the employees. These costs are allowable as direct costs to sponsored award when necessary for the performance of the sponsored award and approved by awarding agencies.

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

Idle Facilities. The costs of idle facilities are unallowable except to the extent that they are necessary to meet fluctuations in workload. If idle facility cost exceeds 10% of facility capital costs expense, then providers need to report this percentage on notes to the financial statements.

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

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

Losses on Other Awards. Any excess of costs over income on any award is unallowable as a reallocated cost of any other award. This includes, but is not limited to, the organization's contributed portion by reason of cost sharing agreements or any under-recoveries through negotiation of lump sums for, or ceilings on, indirect costs.

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. Costs incurred for necessary maintenance, repair, or upkeep of buildings and equipment which neither add to the permanent value of the property nor appreciably prolong its intended life, but keep it in an efficient operating condition, are allowable.

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

Organization Costs. Expenditures, such as incorporation fees, brokers' fees, fees to promoters, organizers or management consultants, attorneys, accountants, or investment counselors, whether or not employees of the organization, in connection with establishment or reorganization of an organization, are unallowable except with prior approval of a plan by DBH and HCPF.

Parent Company/Management Costs. Parent Company/Management Costs/Related Party Transactions will not be allowed unless they are actual costs. These costs need to be supported by a company-wide cost allocation plan, which must be submitted as an appendix to the BHO or CMHC annual financial statement. For instance, the cost of a regional manager who supervises multiple facilities will be that regional manager’s salary appropriately allocated to the respective facilities that are supervised.

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.)

Related Party Transactions. All transactions with related parties are subject to the following requirements:

1) All transactions between related parties for services, rental payments, etc. are required to be adjusted to fair market value (to be determined by the related party)

2) BHOs and CMHCs are required submit Exhibit D in the appendix with documentation of all related party transactions/ payments to related parties.

Rental Costs Under Capital Leases. Rental costs under leases which are required to be treated as capital leases under GAAP, are allowable only up to the amount that would be allowed had the organization purchased the property on the date the lease agreement was executed, i.e., to the amount that minimally would pay for depreciation or use allowances, maintenance, taxes, and insurance. Unallowable costs include amounts paid for profit, management fees, and taxes that would not have been incurred had the organization purchased the facility.

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

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

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

Standard 4. Items of cost should be assigned or allocated to direct service cost centers to the maximum extent practicable; where costs cannot be directly assigned, an allocation methodology must be used.

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

Direct and Traceable Costs

Direct costs, such as direct-service related costs such as personnel salaries, fringe benefits, contracted costs, and supplies, that benefit can be traced directly to one cost center should be assigned directly to the benefitting cost center. Also, any administrative and operating expenses that are specific to one program should be directly assigned to the benefitting cost center.

In some cases, direct costs may benefit more than one program and as such will need to be allocated to different cost centers. See Example 3 in the box to the right for examples of both an assignable direct cost and one that needs to be allocated. These expenses, recorded on the General Ledger need to be distributed to the appropriate cost center that incurred the cost. This ongoing process, known as the functional expense classification (see Standard 2 for more detail) needs to take place over the course of the reporting period. Statistics need to be maintained in order to distribute items of direct cost to the benefitting cost centers. When completing the annual financial statements and supplement cost report, keep in mind that distribution tables and allocations used can be audited for reasonableness; therefore, each Provider should maintain appropriate back-up documentation. The following table provides the suggested statistics that providers can use to allocate costs to the cost centers. Providers may substitute a more readily available allocation base as long as it will not increase the costs charged to certain cost centers. Providers must maintain and make available supporting documentation of their allocation methodology.

Example 3: An example of a direct cost that is directly assignable to one cost center is a receptionist that only works for one program. The entirety of his/her personnel cost would be assigned directly to the program in which he/she works.

An example of a direct cost that is attributable to more than one cost center is a clinician that provides service in multiple programs. Their personnel cost would need to be allocated to each of the benefitting programs based on an allocation statistic.

Indirect Costs

In addition to either assigning or allocating the direct and traceable expense to cost centers, Providers need to identify those costs that benefit the facility as a whole and are not directly traceable to any specific cost center separately. Indirect costs include administrative costs, such as the Executive Director, Finance/Accounting department, and IT department, as well as facility-wide operating expenses such as rent and depreciation, maintenance, and housekeeping. Providers will differentiate these facility-wide overhead expenses from those administrative and operating expenses that are directly attributable to programs (Direct Administrative and Operating

Expenses). See Example 4 in the box below for an example of the difference between direct administrative and operating costs and indirect costs.

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

> "Where an organization's indirect costs benefit its major functions in varying degrees, indirect costs shall be accumulated into separate cost groupings. Each grouping shall then be allocated individually to benefitting functions by means of a base which best measures the relative benefits. Cost groupings shall be established so as to permit the allocation of each grouping on the basis of benefits provided to the major functions. Each grouping shall constitute a pool of expenses that are of like character in terms of functions they benefit and in terms of the allocation base which best measures the relative benefits provided to each function"[3]

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

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

For the CMHCs that will be filing the Supplemental Cost Report (Exhibit C), Schedules 3 and 3A are designed to complete this step down allocation. Please see Chapter 4, the Instructions for Completing the Supplemental Cost Report, for details and instructions on how the allocation works. BHOs should refer to these schedules as an example of how to allocate indirect costs.

When allocating costs, whether allocating direct costs to multiple benefitting cost centers or allocating indirect costs to all cost centers, statistics must be documented and maintained in order to distribute the costs. The following table provides the suggested statistics that providers can use to allocate costs to cost centers. Providers may substitute a more readily available allocation base as long as it will not increase the costs charged to certain direct service cost centers. Providers must maintain and make available supporting documentation of their allocation methodology.

Type of Direct or Indirect Expenditure	Suggested Allocation Statistic (When Unable to Assign to One Cost Center)
Direct Service Salaries and Benefits	Service Activity Log - Staff Time
Purchased Services	Service Activity Log - Staff Time
Staff Travel	Service Activity Log - Staff Time
Salaries & Benefits – Direct Service Supervision & Service Administration	Service Activity Log - Staff Time
Supplies	Full Time Equivalents (FTEs)
Occupancy/ Depreciation/ Interest	Square Footage or FTEs
Operation of Plant	Square Footage or FTEs

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

Human Resources	Full-Time Equivalents (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

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

The cost centers that the CMHCs will use to classify their functional expenses are listed in Chapter 4, Instructions for Completing the Supplemental Cost Report. CMHCs must maintain a functional expense classification system throughout the reporting period in order to complete the Supplemental Cost Report.

Standard 5. The cost-accounting period is the fiscal year used by the Department of Health Care Policy and Financing and the Division of Behavioral Health.

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

CHAPTER 3

AUDITING AND FINANCIAL REPORTING GUIDELINES

CHAPTER 3: AUDITING AND FINANCIAL REPORTING GUIDELINES

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

Substantially all CMHCs will utilize the American Institute of Certified Public Accountants guide for Health Care Organizations. Certain exceptions to this may exist because they may qualify to use the AICPA Guide for Not-For-Profit Organizations. Which guide to use will require the exercise of judgment by the CMHC and its auditor. Excerpts from these guidelines are listed below concerning circumstances under which each guide is utilized. As a general guideline, if the CMHC 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 the Health Care Audit Guide is not utilized, the CMHC will still be required present the supplemental information concerning services provided and the costs associated with those services.

FOUNDATION FOR ACCOUNTING STANDARDS

The following matrix will be complied with by all centers and BHOs and their auditors.

Matrix of Requirements

	Cost Principles	**Grant Management "Common Rule"**	**Grant Management "Administrative Requirements"**	**Audit Requirements**
States, local governments, and Indian Tribes follow:	A-87 Cost Principles for State, Local, and Indian Tribal Governments May 2004	45 CFR 92	A-102 Administrative Requirements for Grants and Cooperative Agreements with State and Local Governments 44 CFR 13 August 1997	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2003
Public & Private Institutions of Higher Education (even if part of a State or local government) follow:	A-21 Cost Principles For Determining Costs Applicable To Grants, Contracts, & Other Agreements With	45 CFR 74	A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74	A-133 Audits of States, Local Governments, and Non-Profit Organizations May 2004

	Educational Institutions May 2004		September 1999	
Non-Profit Organizations follow:	A-122 Cost Principles for Non-Profit Organizations May 2004	45 CFR 74	A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74 September 1999	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2003
For Profit Organizations	48 CFR 31	NA	NA	NA
Hospitals	1) Medicare Cost Principles in Title XVIII of the SS Act of 1934, 2) Research & Development Costs in 45 CFR 74, Appendix E		A-110 Uniform Administrative Requirements For Grants And Agreements With Institutions Of Higher Education, Hospitals, And Other Non-Profit Organizations 45 CFR 74 September 1999	A-133 Audits of States, Local Governments, and Non-Profit Organizations June 2003

EXPENSE CLASSIFICATIONS

Expense categories (by natural classification). These expense categories are to be used in the annual financial statements, in the order presented, to have uniform and consistent categories for the annual combining financial statements.

Personnel:
- Salaries
- Payroll taxes
- Employee benefits

Client:
- Salaries

Payroll taxes & benefits
External doctors, clinical & hospitals
Food
Medical supplies & laboratory
Medications
Purchases from other providers
Supplies & travel

Occupancy:
Janitorial
Maintenance & supplies
Insurance, property
Rent & real estate taxes
Utilities

Operating:
Amortization & depreciation
Dues, fees, licenses & subscriptions
Equipment rental, lease & maintenance
Insurance
Interest
Office supplies
Postage, printing & photocopying
Telephone & pagers
Travel, conferences, & staff development
Vehicles fuel, oil, lease, & maintenance

Other expenses
Uncollectible Receivables / Bad Debts

Professional fees
Audit & accounting
Legal
Other consultants

Donations:
Material & building space
Volunteer services
Hospital care
Psychiatric Medications

Salaries

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

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

Payroll Taxes

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

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

Employee Benefits

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

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

Client

1. Client-**Salaries**

   Used for: salaries paid to clients.

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

2. Client-**Taxes and Benefits**

   Used for: amounts paid for client taxes and benefits.

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

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

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

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

4. Client-**Food**

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

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

meetings are charged to administration. If food is purchased in bulk for several residential programs, the appropriate allocation basis is actual cost requisitions.

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

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

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

6. Client-**Medications**

   Used for: amounts paid for medications used by clients.

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

7. Client-**Purchases from Other Providers**

   Used for: expenses for purchasing services from other providers that provide same or similar services. Examples are: when an agency operates a residential program for some of their clients and also purchases residential services from other providers for some of the clients or when an agency provides mental health programs for most of their clients but does purchase some mental health programs for a few clients.

   Allocation basis: expenses in this classification are always program specific and allocations are not used.

8. Client-**Supplies and Travel**

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

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

Occupancy

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

Used for: expenses resulting from an agency's occupancy and use of owned, rented, lease or donated building and offices. This expense category excludes cost reported elsewhere, e.g., amortization and depreciation.

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

Operating

1. Operating-**Amortization and Depreciation**

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

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

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

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

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

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

   Used for: costs of renting or leasing and maintaining equipment such as computers, office equipment and program equipment.

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

4. Operating-**Insurance**

   Used for: the cost, paid or accrued, of premiums for insurance contracts to reimburse the agency for revenue or property loss caused by various types of events over which the agency has no control, i.e., fire, theft, content and liability. This includes providing coverage for all phases of automotive insurance. These costs could be administrative or program. Costs of buildings' insurance premiums should be reported in the above category titled, Occupancy-insurance, property.

   Allocation basis: insurance premiums are allocated based upon the following criteria:

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

    1. Premiums covering land and buildings should be charged on a basis of square footage of occupancy.
    2. Premiums covering equipment should be based on hours of usage.
    3. Premiums based on payroll hours should be charged on a payroll hour basis.
    4. Premiums based on number of persons served should be charged on a person served basis.
    5. Premiums covering vehicles should be charged based on hours of usage or mileage.

5. Operating-**Interest**

   Used for: expenses incurred for borrowing money. The interest should be incurred at a rate not in excess of what a prudent borrower would have had to pay in an arm's-length transaction in the money market when the loan was made.[4]

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

6. Operating-**Office Supplies**

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

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

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

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

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

8. Operating-**Telephone and Pagers**

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

Used for: telephone and other electronic communication expenses. This includes the regular monthly charge for telephone services, including long distance and installation charges for connecting and disconnecting telephones. Costs associated with leasing or purchasing a communication system are reported in the object classification, equipment rental, lease and maintenance.

Allocation basis: if the expense is identifiable (through examination of telephone statements), then it should be charged directly to the appropriate functional program. Otherwise, the expense should be allocated based upon the number of phones for each program relative to the total number of phones. Example: there are 20 phones in the organization. The case management department has four phones; therefore, 20% of the telephone expense would be allocated to the case management program.

9. Operating-**Travel, Conferences, and Staff Development**

Used for: expenses of staff travel including mileage allowances, hotel, meals and incidental expenses. Expenses associated with providing formal internal and external staff development programs. Includes costs paid to external organizations for training classes, meeting space and equipment rentals.

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

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

Used for: expenses of agency owned or leased vehicles.

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

11. Operating-**Uncollectible (Bad Debts)**

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

Allocation basis: Uncollectible expenses are charged to the various functional programs based upon a verifiable basis which reflects a proportional relationship between revenues generated and loses due to un-collectability. Uncollectable expenses are not an allowable expense for unit cost calculations, and should be shown in the "Other Costs column.

<u>Other Expenses</u>

Used for: all expenses not reportable in another object classification. Careful consideration of the nature of all expenses should minimize the use of this category.

Allocation basis: expenses in this classification are program specific and allocations are not used.

Professional Fees

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

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

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

Donations (Donated In-Kind)

Material and building space
Volunteer services
Hospital care
Psychiatric Medications

Used for: recording the value of donations for material and building space, volunteer services, hospital care, and donated psychiatric medications.

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

Unallowable Costs

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

Auditing Guidelines

These auditing and reporting guidelines have been prepared to assist the independent public accountant (auditor) in examining and reporting on the financial statements of CMHCs and BHOs in Colorado. DBH 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 Audits of Health Care Organizations, as well as the requirements contained elsewhere in this guide.

HCPF and DBH 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 Circular A-133, Audits of States, Local Governments, and Non-Profit Organizations. Accordingly, 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. DBH/HCPF guidelines, as outlined in this section, assume that the auditor will follow those standards and pronouncements.

Statistical System

The independent auditor should document his or her understanding of the statistical information system, confirm that understanding through tests of transactions and data generated and then determine whether the statistical information systems is sufficient and adequate to document and/or report client utilization data and other information required of the CMHCs and BHOs by DBH and HCPF.

Financial Reporting Guidelines

The annual audits of financial statements and the attestation report with respect to the statistical system are the primary documents used to monitor the unit cost reimbursement system and the encounter systems. The audits provide credibility to the reimbursement system and the encounter systems presented to the Legislature. Thus, DBH and HCPF require that the auditor specifically express an attestation opinion on the supplementary information.

Authoritative pronouncements of the accounting profession dictate the form and substance of reports on the audit of supplementary data. Required financial statements are presented as Exhibits A and B, however if changes are made to the Healthcare Audit Guide conforming changes must be made to the financial statement presentation. The Supplemental Cost Report, which is used in part to calculate the Provider's base unit cost, is included in Exhibit C. The required auditor's attestation opinion is to be addressed to these figures.

Management Letter

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

DBH / HCPF requires copies of SAS 115 communication and management letter along with a copy of the response by the CMHC or BHO management to its Board.

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

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

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

Related Party Transactions

As stated in Chapter 2, all BHOs and CMHCs are required to disclose all transactions with and payments to related parties. All BHOs and CMHCs must fill out the table in Exhibit D of the Appendix and submit to HCPF/DBH. In lines 1-15 of the table, please disclose all related party transactions by the following information:

1) Name of Related Party
2) Description of Goods/Services Purchased
3) Amount of Transaction/Payment
4) Fair Market Value of Goods/Services Purchased (As Reported on Annual Financial Statements)

This form must be completed and submitted by the BHOs and CMHCs at the same time as the annual financial statements.

Third-Party Liability

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

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

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

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

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

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

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

Special Instructions for BHO Financial Statements

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

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

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

Fiscal and Statistical -- Supplementary Schedules:

The supplementary schedules consist of two pages.

1. Expense Summary by Function;
2. Clients Receiving Services by Function and Inpatient Statistics;

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

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
- 3. Inpatient
- 4. Encounter-based Services with RVU Weights (see Chapter 4, pg. for a definition
- 5. School-based
- 6. Other State Plan Services

Non-State Plan (B3 waiver services)
- 7. Clubhouse & Drop-in centers
- 8. Vocational services
- 8. ACT services
- 10. Prevention & Early intervention
- 11. Residential services
- 12. Home based services
- 13. Intensive case management
- 14. Respite care
- 15. Recovery Services

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

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

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

- Some BHOs are paying per diem rates that include physician services; others pay physician services, case management, or other services separately. If material, show these costs separately on line 2a of the schedule.
- Be prepared with 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. (Perhaps make this a global statement across all of these service categories)

- Be prepared with 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.

- Be prepared to discuss 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 functions. If you do not apply direct costing to the functional areas, be prepared with documentation to support the allocations.

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:* Be prepared with a detailed schedule at the site review.
- E 2a, 2b, 2c *IBNRs*: Be prepared with a detailed schedule at the site review. Be prepared to discuss and document authorization processing and actuarial information used to accrue expenses entered on this line.
- E3: *Provision for Bad Debt*
- E4 *Other:* Be prepared with a detailed schedule to support the allocation.

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

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

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

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

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

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

Additional inpatient information:

- Total Inpatient Census Days: the basis for this information is claims paid.
- Prepare a detailed schedule of the days by specific hospital for review at the site visit.
- Inpatient Days by Age: these days should tie the census days section.
- The appropriate clinical person should analyze the total re-admissions. Be prepared to discuss the readmissions during the BHO review visit.
- The discharge average -- Cost ($s) is the cost per discharge.

CHAPTER 4

INSTRUCTIONS FOR COMPLETING THE SUPPLEMENTARY COST REPORT

CHAPTER 4: INSTRUCTIONS FOR COMPLETING THE SUPPLEMENTAL COST REPORT

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

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

Encounter-based Mental Health Services with RVU Weights:
Costs related to the provision of services which generate encounters with clearly defined Mental Health CPT/HCPCS billing codes and also have established RVU weights assigned to them. Cost of providing these encounter-based services with RVU weights which are reimbursed by other third party payers (i.e. commercial insurance, self-pay, etc.) should also be captured in this cost center.

In addition to services provided through Medicaid and other third party payers, costs associated with the following DBH Contract-Funded Programs should also be included in Encounter-based Mental Health Services with RVU Weights:

Indigent Client General Fund
Indigent Client Block Grant
Assertive Community Treatment (ACT)
Criminal Justice
MHCD Assertive Community Treatment Intensive Case Management (AIM) Program
Veterans Mental Health Services

Encounter-based Mental Health Inpatient Hospital Claims without RVU Weights:
Costs related to the provision of inpatient services which generate encounters with any kind of billing codes and do not have established RVU weights assigned to them. The cost of providing encounter-based services with RVU weights, such as professional services in an inpatient setting, should be classified under the Encounter-based Mental Health Services with RVU Weights cost center.

Encounter-based Residential Services without RVU Weights
Cost related to the provision of bundled residential services that do not have established RVU weights assigned to them should be reported in this column. These residential services are provided in Short-Term Residential Treatment Facilities, Long-Term Residential Treatment Facilities, or Acute Treatment Facilities. The cost of providing encounter-based services with RVU weights in a residential setting should be classified under the Encounter-based Mental Health Services with RVU Weights cost center.

Encounter-based Substance Abuse with RVU Weights:

Costs related to Substance Abuse with RVU weights will be reported in this cost center.

Encounter-based Substance Abuse without RVU Weights:
Costs related to Substance Abuse without RVU weights will be reported in this cost center.

Non-Encounter-based Substance Abuse:
Costs related to non-encounter-based Substance Abuse will be reported in this cost center.

Encounter-based Other Mental Health Services without RVU weights:
All cost related to other mental health services that do not have established RVU weights assigned to them. Those services are usually lab services or emergency services with a primary mental health diagnosis.

Other Non-encounter based Mental Health Costs:
Costs related to other mental health related programs that do not generate any encounters should be reported and captured in this cost center. DBH costs, except for the five encounter-based contracts listed above, should be reported in this cost center. The contracts are as follows:

Psychiatric Medication
Early Childhood Specialist
Licensed Inpatient
Alternative Services – CCI/ARU
Alternative Services – Aftercare
Alternative Services – CMHIP
Alternative Services – CMHIP Children
PATH
Detention Mental Health
Juvenile Family Advocacy
Vocational Rehabilitation
Other (if a CMHC received other DBH contracts, the title of the contracts must be specified on the cost report)

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

Examples of BHO Administrative costs include, but are not limited to, cost associated with the following:

- CCAR use
- Grievance process

- Appeal process, including legal costs for Administrative Law Judge (ALJ) hearings and preparation
- Office of Member & Family Affairs requirements
- Performance Improvement Plan (PIP) requirements
- External Quality Review Organization (EQRO) process to include data validation, performance measures and chart and coding audits
- Report preparation and submission (Alternative Services, Inpatient and Outpatient Benefit Limits, Third Party Identification and Payments)
- Network Adequacy, Access, Bed Days, FQHC Payments, PRTF/TRCCF Payments, Performance Measures, Evidence Based Practices (EBP), Data Certifications
- Access Rules/Requirements

An administration reporting unit is necessary to capture Provider-wide costs such as Executive Director, CFO, Accounting, IT, and other administrative functions essential to the operation of the Provider. Other expenses that are not traceable to a cost center will be reported discretely on the cost report and allocated to the direct cost center.

See the table on page 2-11 of Chapter 2 for the suggested statistics that the provider should use to allocate costs.

The provider will allocate direct service costs that cannot be assigned to one cost center based on the allocation methodology outlined in Chapter 2, Standard 4. Personnel costs (salary, wages, benefits, etc.) for direct service employees must be allocated using time spent. For instance, a direct service salaried employee who works in both the Medicaid Capitation Program providing encounter-based services ***and*** works in a DBH Contract-funded capacity program must have their personnel expenses allocated to the two different cost centers based on the time spent working in each. Acceptable methods for allocating salaries and other personnel costs to different functional expense classifications include:

- Journal entries in accounting system
- Service activity logs
- Time study

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

Once the provider has completed the functional expense classification to assign or allocate all direct costs to the different cost centers, the provider should follow the instructions below to complete the Supplemental Cost Report.

SUMMARY SCHEDULE 1

The Summary Report shows the total allowable costs that are allocated to the various payer sources for encounter-based services with RVU weights. The cost report performs the allocation by completing the schedules as explained below. Column 1, Total Allocated Costs for Encounter-based Mental Health Services with RVU Weights is pulled directly from Schedule 5, Line 115. In Column 2, providers are to report the total number of clients served by the various payer sources for encounter based services. It is understood that these client counts may be duplicated for lines 7-11. Please allocate the client count to the primary payer on the billing documentation. Column 3 calculates the average cost per client by dividing column 1 by column 2. Line 14 will calculate an

average facility average client cost. The centers must enter the total unduplicated client count in Column 2, to get a total facility average cost per client.

SCHEDULE 2 – TRIAL BALANCE OF EXPENSES

Schedule 2 records the trial balance for the provider at the end of the reporting period. The costs reported on Schedule 2 must come directly from the Provider's trial balance, which includes all activities conducted by the reporting entity. All of the items of cost listed on Schedule 2 may not apply to all Providers required to complete and submit the CMHC Cost Report. **The standard preprinted line numbers and cost center descriptions cannot be changed or modified by the Provider.**

Lines 1-9 – Direct Program Staff

Full-Time Equivalents (FTEs) and salary data for direct program staff should be recorded in lines 1-9. In Column 1, Full-Time Equivalents, the provider should list the number of FTEs employed by the CMHC at each of the different category/education levels. An FTE will be based on a 40-hour workweek (number of hours worked / 2080). Column 2, Indirect (Not Traceable to Direct Cost Centers) captures those costs that cannot be allocated directly to one of the cost centers described above; therefore, no entry should be made in Column 2 on lines 1-9. In Columns 3-11, the provider will enter the salaries, wages, and other non-fringe compensation for the direct care program staff incurred by each cost center.

See Example 2 in Chapter 2 for an explanation of administrative/operating costs that are treated as direct costs

The categories of direct service staff are as follows[5]:

1. **Direct Program Management Staff:** Staff that perform management, oversight, and administrative functions that are directly traceable to the cost center where they are reported. Examples include program managers, program directors, program secretaries, etc.
2. **Bachelor's Degree Level:** HIPAA Modifier HN
3. **Master's Degree Level:** HIPAA Modifier HO
4. **Doctoral Level**: HIPAA Modifier HP
5. **MD**
6. **Intern:** HIPAA Modifier HL
7. **Less than Bachelor's Degree Level:** HIPAA Modifier HM
8. **Other Direct Program Staff**: Report any direct program staff that cannot be classified in categories 1-7.
9. **Program Support Staff (Clerical, Maintenance, House/Groundskeeper):** These staff must be direct and traceable to the cost center where they are reported. If they are not traceable, then they are to be reported as Indirect Costs.

Line 10 automatically computes the total direct program salary expenses for Columns 3-11; the provider should not enter any data on this line.

Line 11 – Fringe Benefits

See Example 4 in Chapter 2 for the difference between Direct Administrative or Operating Costs and Indirect Costs

[5] HIPAA Code Set 2: Education level of treatment staff: http://www.hipaa.samhsa.gov/HCPCSCodesNumericList2005.doc

No entry in Columns 1-2 on line 11. For Columns 3-11, the provider should report the fringe benefit amount paid to direct program staff, either by entering the amount from the trial balance or using a standard fringe benefit percentage. If a standard fringe benefit percentage is used, the auditor should disclose the methodology for calculating the percentage in the notes to the financial statements.

Fringe benefits include all costs encompassed by the definitions of "Employee Benefits" and "Payroll Taxes" in Chapter 3.

Line 12 automatically computes the Total Employee Compensation and Benefits for Columns 3-11; the provider should not enter any data on this line.

Lines 13-14 – Purchased Services and Staff Travel

No entry in Columns 1-2 on lines 13 and 14. For Columns 3-11, the provider should report the purchased services for each of the direct service cost centers on line 13. **Purchased Services** include all compensation to direct care workers and consultants engaged by the provider on a contract basis to provide direct care services for the clients.

On line 14, the provider should report the staff travel costs for each of the direct service cost centers. **Staff travel** includes all expenses of staff travel including mileage allowances, hotel, meals and incidental expenses related to the provision of direct care services.

Line 15 – Client Costs

No entry in Columns 1-2 on line 15. For columns 3-11, the provider should report all client costs attributable to the direct service cost centers.

Client costs include all costs encompassed by the "Client" expense category in Chapter 3.

Line 16 – Other Expenses

No entry in Columns 1-2 on line 15. For columns 3-11, the provider should report all other costs attributable to the direct service cost centers.

Other expenses are all those costs that are not captured in the direct program staff costs in lines 1-9 or administrative, client, and operating costs in lines 13-25. Providers and auditors must identify which costs are included in line 15 in their notes to the financial statements.

Line 17 – Occupancy/Depreciation/Interest

No entry in Column 1 on line 17. For column 2, the provider should report all rent/depreciation/interest costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all rent/depreciation/interest costs that can be allocated directly to the direct service cost centers.

Occupancy/Depreciation/Interest includes all expenses resulting from an agency's occupancy and use of owned, rented, lease or donated building and offices, as well as costs defined under "Operating – Amortization and depreciation" and "Operating – Insurance" in Chapter 3. Please refer to Chapter 2 for the accounting and cost reporting standards for related party transactions.

Line 18 – Administration and General

Enter FTE's in Column 1 on line 18. For column 2, the provider should report all administration and general costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all administration and general costs that can be allocated directly to the direct service cost centers.

Administration and general costs include expenditures for the overall direction of the organization, general record keeping, human resources, business management, budgeting, general board activities and related purposes for meeting organizational goals and objectives. "Overall direction" includes the salaries and expenses of the chief officer of the organization and his or her staff.

Line 19 – Professional Fees

No entry in Columns 1 on line 19. For Column 2-11, enter fees and expenses of general professional consultants who are not employees of the agency and are engaged as independent contractors for specified services on a fee or other individual contract basis.

Examples: auditing, accounting, and legal.

For column 2, the provider should report the costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report the costs that can be allocated directly to the direct service cost centers.

Line 20 – Maintenance and Repairs

No entry in Column 1 on line 20. For column 2, the provider should report all maintenance and repairs costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all maintenance and repairs costs that can be allocated directly to the direct service cost centers.

Maintenance and Repairs includes all costs associated with maintaining and/or repairing buildings, equipment, vehicles, computer equipment and other assets needed for operation.

Line 21 – Operation of Plant

No entry in Column 1 on line 21. For column 2, the provider should report all operation of plant costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all operation of plant costs that can be allocated directly to the direct service cost centers.

Operation of Plant includes that have been incurred by a central service organization or at the departmental level for the administration, supervision, and provision of utilities (exclusive of telephone expense) and protective services to the physical plant.

Line 22 – Housekeeping

No entry in Column 1 on line 22. For column 2, the provider should report all housekeeping costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all housekeeping costs that can be allocated directly to the direct service cost centers.

Housekeeping includes all costs associated with the janitorial/housekeeping/grounds-keeping staff, laundry and linen services, and supplies needed for the everyday maintenance of the facility.

Line 23 – Central Services and Supplies

No entry in Column 1 on line 23. For column 2, the provider should report all central services and supplies costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all central services and supplies costs that can be allocated directly to the direct service cost centers.

Central Services and Supplies includes all costs associated with the department that records the cost of supplies purchased by all direct cost reporting units.

Line 24 – Medical Records

No entry in Column 1 on line 24. For column 2, the provider should report all medical records costs that cannot be allocated directly to any of the direct service cost centers. For columns 3-11, the provider should report all medical records costs that can be allocated directly to the direct service cost centers.

Medical Records includes all costs associated with the department that maintains and provides patient records.

Line 25 automatically computes the total direct administrative expense for columns 3-11, providers should not enter any data on this line.

Line 26 automatically computes the total direct expense for columns 3-11; providers should not enter any data on this line.

Line 27 – Overhead Allocation

Line 27 automatically allocates the Indirect (Not Traceable to Direct Cost Centers) costs to each of the direct service cost centers based on Schedule 3 and 3A; providers should not enter any data on this line.

Line 28 – Unallowable Costs

Centers may choose to enter the unallowable cost in sum on line 28, column 2 or they may allocate the unallowable costs attributable to direct service cost centers.

Line 29 – Total Allowable Cost

Line 29 automatically computes the total allowable cost for each of the direct service cost centers by adding the overhead allocation to the direct expense, then subtracting the unallowable cost. The provider should not enter any data on line 29.

Line 30 – Total Cost

Line 30 automatically computes the total cost in Column 12 by adding Line 29, Total Allowable Cost and Line 28, Unallowable Cost. This amount must reconcile to Total Expenses in the Statement of Operations of the annual financial statements.

SCHEDULE 3 – INDIRECT (NOT TRACEABLE TO DIRECT COST CENTERS) ALLOCATION

Schedule 3 automatically allocates the Indirect (Not Traceable to Direct Cost Centers) Expenses reported by the provider on Schedule 2 – Trial Balance of Expenses based on statistics from Schedule 3A – Indirect Allocation Statistics. The providers should not enter any data on Schedule 3.

SCHEDULE 3A – INDIRECT ALLOCATION STATISTICS

See the table on page 2-11 for recommended allocation statistics for indirect costs

Schedule 3A collects statistics allocation bases (square footage, FTEs, meals, etc.) for the purposes of equitably allocation the Indirect (Not Traceable to Direct Cost Centers) Expenses to each of the cost centers, as defined above.

As stated in Chapter 2, Standard 4 providers must keep detailed back-up of statistics used to allocate indirect costs. If it can be demonstrated that the use of a different statistic would result in a more equitable allocation, or that a more readily available base would not increase the costs charged to certain direct service cost centers, then the provider may use the alternative statistic. Providers must maintain documentation of statistics, referred to as allocation bases in the instructions below, used and make such documentation available upon request.

For each expense reported on Schedule 2 Column 2 (Indirect) Lines 17-25, a corresponding allocation statistic must be entered on Schedule 3A. This will ensure the indirect costs are allocated appropriately.

Column 1 – Occupancy/Depreciation/Interest

In the space provided above Column 1 (AB:____), enter the allocation base used to allocate indirect occupancy/depreciation/interest expense. No entry on line 1 in Column 1. For lines 2-17,

enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 2 – Administration & General

In the space provided above Column 2 (AB:____), enter the allocation base used to allocate indirect administration and general expense. No entry on lines 1-2 in Column 2. For lines 3-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 3 – Professional Fees

In the space provided above Column 3 (AB:____), enter the allocation base used to allocate indirect professional fees. No entry on lines 1-3 in Column 3. For lines 4-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 4 – Maintenance & Repairs

In the space provided above Column 4 (AB:____), enter the allocation base used to allocate indirect maintenance and repairs expense. . No entry on lines 1-4 in Column 4. For lines 5-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 5 – Operation of Plant

In the space provided above Column 5 (AB:____), enter the allocation base used to allocate indirect operation of plant expense. No entry on lines 1-5 in Column 5. For lines 6-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 6 – Housekeeping

In the space provided above Column 6 (AB:____), enter the allocation base used to allocate indirect housekeeping expense. No entry on lines 1-6 in Column 6. For lines 7-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 7 – Central Services and Supplies

In the space provided above Column 7 (AB:____), enter the allocation base used to allocate indirect central services and supplies expense. No entry on lines 1-8 in Column 7. For lines 8-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

Column 8 – Medical Records

In the space provided above Column 8 (AB:____), enter the allocation base used to allocate indirect medical records expense. No entry on lines 1-9 in Column 9. For lines 10-17, enter the statistics for the allocation base chosen for each cost center. Line 18 automatically computes the total for all cost centers; providers should not enter any data on line 18.

SCHEDULE 4 – UTILIZATION (ENCOUNTER-BASED MENTAL HEALTH SERVICES WITH NON-FACILITY RVU WEIGHTS)

Schedule 4 collects utilization data for Encounter-based Mental Health Services with RVU weights, as defined above, for all services provided in a Non-Facility setting. All services provided outside of the Community Mental Health Center should be considered non-facility place of service, and will use non-facility RVU weight.

Units of service reported on Schedule 4 should only be related to the costs reported on Schedule 2, Column 3 Encounter-based Mental Health Services with RVU weights.

In order to complete schedules 4 and 4A, 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. Service/revenue code
    b. POS code
    c. Date of Service
    d. Number of Units
4. Payer source

From the service encounter database, providers will track utilization over the course of a year for input into Schedules 4 and 4A. The following instructions describe how Schedule 4 organizes the utilization data by payer source. Please input units according to the primary payer listed on billing documentation.

Column 1 – Medicaid Capitation

Providers should report all units of service provided in a Non-Facility setting to Medicaid Capitation clients according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled “Description”, and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 2- Medicaid Capitation (External BHO)

Providers should report all units of service provided in a Non-Facility setting to Medicaid Capitation clients from an external BHO according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled “Description”, and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 3 – Medicaid Fee-for-Service

Providers should report all units of service provided in a Non-Facility setting that are billed to Medicaid on a fee-for-service basis according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 4 – DBH

Providers should report all units of service provided in a Non-Facility setting to DBH according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 5 - Medicare

Providers should report all units of service provided in a Non-Facility setting to Medicare according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 6 - Other

Providers should report all units of service provided in a Non-Facility setting to all other types of clients (Private Insurance, Self-Pay, etc.) according to the CPT/HCPCS codes listed in lines 1-114. Units are defined in the column labeled "Description", and units reported must be of the same nature and time period as described in this column. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 7 – Total Units

Column 7 automatically calculates the total units for each CPT/HCPCS procedure code across all payer sources as reported in Columns 1-6; the provider should not enter any data in Column 7. Line 115 automatically calculates the total units; the provider should not enter any data in this line.

Column 8 – Total Relative Value Units

Column 8 automatically calculates the total relative value units for each CPT/HCPCS procedure code by multiplying the total units in Column 7 by the Non-Facility RVU weight specific to each procedure code; the provider should not enter any data in Column 8. Line 115 automatically calculates the total relative value units; the provider should not enter any data in this line.

SCHEDULE 4A – UTILIZATION (ENCOUNTER-BASED SERVICES WITH FACILITY RVU WEIGHTS)

Schedule 4A collects utilization data for Encounter-based Services with RVU weights, as defined in above, for all services provided in a Community Mental Health Center (Facility) setting. Units of service reported on Schedule 4A should be in agreement with costs reported on Schedule 2.

To complete Schedule 4A, providers should follow the instructions given for Schedule 4 above, reporting instead those services billed under a Facility RVU weight.

SCHEDULE 5 – BASE UNIT COST CALCULATION

Schedule 5 automatically calculates the provider-specific base unit cost and cost of encounters associated with the different payer sources. The provider should not enter any data on Schedule 5.

At the top of Schedule 5, the Total Allowable Cost for Encounter-Based Mental Health Services is pulled in from Schedule 2, Column 3, Line 29. Next, the Total Relative Value Units are pulled in by adding Schedule 4, Column 8, Line 115 and Schedule 4A, Column 8, Line 115. Then, the Base Unit Cost is automatically calculated by dividing the Total Allowable Cost for Encounter-Based Mental Health 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.

Column 3 – Medicaid (Capitation) Costs

Column 3 automatically calculates the cost associated with the Medicaid Capitation Program by the following formula:

> Base Unit Cost * ((Non-Facility Medicaid Capitation Units*Non-Facility RVU Weight)+(Facility Medicaid Capitation Units*Facility RVU Weight))

Column 4 – Medicaid (Capitation) Costs from an External BHO

Column 4 automatically calculates the cost associated with the Medicaid Capitation Program (external BHO) by the following formula:

Base Unit Cost * ((Non-Facility Medicaid Capitation Units (external BHO)*Non-Facility RVU Weight)+(Facility Medicaid Capitation Units (external BHO)*Facility RVU Weight))

Column 5 – Medicaid (FFS) Costs

Column 5 automatically calculates the cost associated with the Medicaid Fee for Service program by the following formula:

Base Unit Cost * ((Non-Facility Medicaid FFS Units*Non-Facility RVU Weight)+(Facility Medicaid FFS Units*Facility RVU Weight))

Column 6 – DBH

Column 6 automatically calculates the cost associated with DBH encounters by the following formula:

Base Unit Cost * ((Non-Facility DBH Units*Non-Facility RVU Weight)+(Facility DBH Units*Facility RVU Weight))

Column 7 – Medicare Costs

Column 7 automatically calculates the cost associated with Medicare encounters by the following formula:

Base Unit Cost * ((Non-Facility Medicare Units*Non-Facility RVU Weight)+(Facility Medicare Units*Facility RVU Weight))

Column 8 – Other Costs

Column 8 automatically calculates the cost associated with all other mental health encounters by the following formula:

Base Unit Cost * ((Non-Facility Other Units*Non-Facility RVU Weight)+(Facility Other Units*Facility RVU Weight))

SCHEDULE A – DBH RVU Cost Calculation Schedule

Schedule A requires the providers to report the units for different DBH-contracted programs, both those reported in the Encounter-based Mental Health Services with RVU Weights. Totals from Schedule A should tie to column 6, DBH programs, of Schedule 5. To complete schedule A, providers should follow the instructions for Schedule 4 and 4A –Utilization for Facility and Non-Facility Encountered Base Services. If the center receives other DBH contracts than those listed on Schedule A, this must be reported in columns 28-40.

SCHEDULE B – RESIDENTIAL SERVICES DETAIL

Schedule B requires providers to report information about the Residential facilities in greater detail. The provider should list only as many Residential facilities as it operates.

Column 1 - Name of Facility

List the names of all the Residential facilities operated by the CMHC, using as many of lines 1-12 as necessary.

Column 2 – Type of Facility

Specify which type of facility (Short-Term Treatment, Long-Term Treatment, Supported housing or ATU)

Column 3 - Bed Capacity

List the total number of beds per State Fiscal Year (SFY) that the facility is licensed to operate in each of the facilities.

Column 4 - Census Days

List the total number of bed days occupied per SFY in each of the facilities.

Column 5 - Utilization Rate

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

Column 6- Total

The total expense per residential facility should be entered into Column 6.

CHAPTER 5

ABILITY-TO-PAY GUIDELINES

CHAPTER 5: ABILITY-TO-PAY GUIDELINES

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

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

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

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

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

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

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

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

CHAPTER 6
Alcohol and Drug Abuse

Managed Service Organizations
And
Sub-recipients

Alcohol and Drug Abuse Contractors

CHAPTER 6: ALCOHOL AND DRUG ABUSE

Note: This chapter is still in draft form and will be updated at a later date. If a BHO has an agreement with ADAD as an MSO, please contact Laurel Healey at ADAD.

Introduction:

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

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

Financial reports included in this Chapter are to be followed to the maximum extent possible to provide uniformity and comparability.

SECTIONS INCLUDED IN THIS CHAPTER:

I. Internal Controls
II. Contracts
III. Financial Statement Presentation

EXHIBITS RELEVANT TO THIS CHAPTER IN THE APPENDIX:

E. MSO Financial Statement Presentation
F. MSO Sub-Recipient Reporting Requirements

I. Internal Controls and Level of Care System

1. Internal Controls

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

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

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

II. Contracts

1. Types of MSOs

a) A single stand-alone entity that has been awarded a MSO contract. This could be a for-profit, not-for-profit or governmental organization – until July 2003, when governmental organizations are no longer eligible for MSO "designation".
b) A division or other type of subsidiary relationship with a larger organization. The larger organization could be a for-profit, not-for profit or governmental entity.

2. Contract Compensation

MSOs are compensated for delivery of services. In order to fully earn the contracted compensation the MSO must provide a minimum of ninety-five percent (95%) of the encounters specified in the contract. Payments on the contract are initially made at one-twelfth (1/12) of the contracted compensation and are adjusted in subsequent months if minimum services are not delivered.

The costs of providing substance abuse services must be at least ninety-five percent of the substance abuse-related compensation. Should costs fall below the ninety-five percent, the MSO or Sub-recipient may be allowed to keep the excess funds, provided the MSO/Sub-recipient submits a plan for approval to the State of Colorado. The plan should indicate how excess funds will be spent in the subsequent year to further the goals of providing alcohol and drug related services.

Audit Considerations

Auditors should compare accumulated encounters with reported encounters to ensure that all revenues received have been earned in accordance with the contract provisions listed above.

Auditors should test the calculation of excess revenues in accordance with the contract, if any, and the resultant deferred revenue or liability accounts. In cases were a MSO/Sub-

recipient is subject to a State approved plan to spend excess funds, the auditor should test that the expenditures meet the terms of the plan. In testing the use of savings requirement, prior year use of savings revenue that is recognized in the current year, should be excluded from the test of excess revenues over expenses.

Any waiver granted by DBH to these provisions will be made upon a written request submitted by the Organization. The request must ask for a specific amount of excess revenue to be waived and state the purpose for which it is being waived. For example, Organization Y might request a waiver of $100,000 of excess revenue because this is the amount of cash it is investing as a down payment on a capital expenditure such as a new software system. DBH will consider waiver requests based on major capital acquisition and other extraordinary, non-operating expenses involving large amounts of the Organizationls cash reserves. Under no circumstances will waivers be considered for non-alcohol related purposes.

Audit reports should include disclosures, concerning the nature of the deferred revenues and requirements of expenditure plans.

III. Financial Statement Presentation

Required reporting

1. Basis of Annual Financial Statement Presentation

MSOs shall submit an annual audit report. Annual financial statement should conform to the current version of AICPA Audit Guides as appropriate. Sub-recipients receiving payments greater than $100,000 are required to be audited by contractual obligation with the MSO. Sub-recipients may also have additional reporting requirements, such as mental health reporting, RTC reporting, and OMB Circular A-133 reporting requirements.

Example reports for MSO organizations are presented in Exhibit E in the Appendix.

Example reports for Sub-recipients are presented in Exhibit F in the Appendix.

2. Supplementary Audit Schedules

MSOs shall present revenues and expenses in supplemental schedules in the format presented in Exhibit E. The schedules are to be presented for the organization as a whole. Agencies operating more than one MSO, with potentially multiple contracts, should present one Schedule of Revenue and one Schedule of Expenses in the annual audit and be prepared to have available upon request of the State, individual schedules supporting each MSO operated.

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

3. Attestation Letters

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

"The audit referred to above was directed primarily toward formulating an opinion on the financial statements of Example Managed Service Organization taken as a whole. The supplementary information is presented for purposes of additional analysis as required by the State of Colorado, Department of Human Services and is not necessary for fair presentation of the financial position, results of operations, or cash flows for Example Managed Service Organization. The supplementary information has been subjected to the auditing procedures applied in the audit of the basic financial statements and, in our opinion, is stated fairly in all material respects only when considered in conjunction with the financial statements taken as a whole."

4. Management Letter

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

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

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

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

AICPA Guides

Substantially all MSOs will utilize the American Institute of Certified Public Accountants guide for Health Care Organizations. Other organizations will qualify to use the AICPA Guide for Not-

For-Profit Organizations. Contractors organized for profit may fall under other audit guides. Which guide to use will require the exercise of judgment by the MSO and its auditor. Excerpts from the American Institute of Certified Public Accountants guide for Health Care Organizations and AICPA Guide for Not-For-Profit Organizations are included in Chapter 5 of this guide. As a general guideline, if the MSO 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 or Not-For-Profit organizations. If the Health Care Audit Guide is not utilized, the MSO will still be required to present the supplemental information concerning revenues and expenses.

Sub-recipients may fall under a number of AICPA Audit Guides and as such will present required information in a number of acceptable formats, including segment reporting, functional expense reporting, and as supplemental information.

AICPA Guide for Health Care Organization

Applicability

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

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

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

Auditing Guidelines

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

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

audit guide being used, the financial statements should disclose all subcontractors receiving over $50,000.

Please refer to Exhibit E for Example Financial Statements and Schedules for Managed Service Organizations. Exhibit F contains Example Financial Information Presentation for Sub-Recipients of Managed Service Organizations.

CHAPTER 7

MANAGEMENT OF CLIENT FUNDS

CHAPTER 7: MANAGEMENT OF CLIENT FUNDS

I. Beneficiaries Receiving Services in Long Term Care Facilities

A. INTRODUCTION

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

B. CLIENT RIGHTS AND FACILITY'S RESPONSIBILITIES

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

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

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

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

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

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

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

7. Deposit of clients' Funds:

   a. The facility must deposit clients' personal funds in an interest-bearing checking and/or savings accounts (pooled account) that are separate from any of the facility's operating accounts and that credits all interest earned on these funds to that account.
   b. An imprest petty cash fund may be established from this account to more efficiently service the clients' needs.
   c. All bank accounts established for the maintenance of residents; personal funds shall be clearly designated as a "client trust fund account".
   d. All interest earned on client funds entrusted to the facility on the client's behalf must be allocated and distributed to the clients based on the average daily balance each client has on deposit with the facility. The client shall have the right to waiver participation in the allocation of interest for the month of discharge, withdraw his or her account balance and receive an accounting for these funds at the date of discharge rather than wait for an interest allocation to be credited to the client's account following the facility's accounting close for the month of discharge.

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

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

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

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

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

13. Limitation on charges to personal funds:

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

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

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

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

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

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

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

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

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

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

A. INTRODUCTION

Part I. of Chapter 8 is designed to accommodate those beneficiaries who are patients of long term care facilities, i.e., nursing homes and other institutional care. Part II. is designed to accommodate those beneficiaries who are clients receiving services through community-based mental health centers or clinics, and the community mental health center or clinic is the representative payee. Much of Part II. is based on information found in the Social Security Administration Publication No. 95-10076. Part II. was reviewed by the Public Affairs Specialist of the Denver Social Security Office. When appropriate, State policy or suggestions are indicated.

A beneficiary is a person who receives Social Security benefits. In general, a person who has worked and had money withheld from earnings, can get a Social Security benefit if he or she

becomes disabled. The amount that someone receives depends on the age at which he or she retires or becomes disabled, how long he or she worked, and the amount of earnings.

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

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

B. ACCOUNTING AND AUDITING

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

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

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

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

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

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

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

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

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

4. Debts incurred by client. As payee, you are not liable for debt incurred by your client. Permission must be given by the local SSA office before you make arrangements to pay a client's debt which is not related to meeting their basic needs (i.e. credit card debt, or paying past due cable bill so they can resume service IS NOT a basic need). SSA or SSI benefits can only be used to pay debt, if their current basic needs are met.

- If they owe back rent, or they will lose their housing, this is a basic need, and you do not need SSA permission to pay this type of debt.
- The agency must use appropriate judgment when large retroactive benefit checks are received.

D. ACCOUNTING ISSUES

1. Bank Account

a) Separation of Funds: Each beneficiary's fund transactions and balance must be accounted for separately and on a regular basis. MHS suggests monthly accounting; quarterly is the accounting period that the State considers as a minimum standard.

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

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

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

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

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

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

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

2. Interest

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

- Earned Interest: Banking arrangements are typically handled in one of two ways. The first is that each transaction (deposit, disbursement) will be charged a minimum fee, by the bank, and deducted from the account. This scenario will most likely provide interest to be credited to the account. The second is to have zero interest credited to the account while the bank offsets any transaction charges with earnings credit.
- To allow beneficiaries to earn interest on their cash balance deposited in the bank, and not pay for the banking charges, the agency may choose to fund the costs associated with maintaining the checking account. The agency may also choose to use agency funds on deposit that accumulates bank earnings credit to offset some or all of the banking costs.

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

3. Cost of Administering the Collective Account
a) The agency may charge the individual beneficiary's specific account a fee for administering the Representative Payee Collective Account.
b) The agency must apply to the local SSA office to be approved as an entity who can charge a fee for payee services. The local SSA office will indicate which documents must be provided before blanket approval can be given. Once approval is granted, SSA will issue a note to the entity. Only then can the agency request of SSA, to charge a fee on a case by case basis. Each time the agency seeks permission to charge a fee, the client will receive a formal notice from SSA saying it is allowing the agency to charge an ongoing fee.
c) Maximum monthly fees are the lesser of 10% of their total benefits or $25 per month. If they have a drug and or alcohol addiction the fee can be the lesser of 10% of their benefits or $50 per month.

4. Collective Account Charges
a) Overdraft charges are generally a result of poorly managing the account and therefore should be the responsibility of the agency.
b) Stop payment and re-issuance charges could be charged to the individual beneficiary's account or the administrative account, dependent upon the cause of the stop payment. The agency should include criteria in their written policies and procedures.
- Example: the client loses or misplaces the check and the original check is not available; the charge could be to the individual beneficiary's account.
- Example: the check is "lost in the mail"; the charge could be to the administrative account.

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

E. RESPONSIBILITIES OF THE AGENCY ACTING AS REPRESENTATIVE PAYEE

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

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

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

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

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

6. The agency has a responsibility to properly educate and train all staff persons who have an involvement with representative payee funds. This includes written guidelines as well as periodic education of federal and state rules and regulations as needed. Often, the local Social Security office can provide materials and assistance.

F. AGENCY DISTRIBUTION OF DUTIES

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

2. The person who assists the client on a day-to-day basis through the case management function is generally the person who is aware of changes that may affect the client's eligibility for benefits or the amount of the benefit. Certain changes need to be reported to

the local Social Security office. The actual reporting requirements may vary between the different funding sources. These changes include, but are not limited to: death, a change of residence, employment changes, receipt of additional government benefits, institutionalization (hospital, nursing home), imprisonment for a crime that carries a sentence of over one calendar month, changes in marital or living arrangements, or changes in income or resources.

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

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

G. GUIDELINES FOR THE USE OF BENEFICIARY'S FUNDS

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

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

2. Non-covered Health Related Expenses: This category includes medical and dental care not provided by Medicare, Medicaid or other third party payer.
    - Medical care: Included is the cost for physical care and a fee for mental health services based on the agency's sliding fee policies. In some communities, free or reduced medical care may be offered through local medical schools or other community organizations.
    - Dental care: In some communities, free or reduced dental care may be offered through local dental schools or other community organizations.
    - Eyeglasses, hearing aids and other items necessary for good health care.
    - Beneficiaries who are 27-10 certified are required to have medical care and emergency dental care. The agency should review the appropriate regulations to assure compliance. (CRS 27-10, 106 Certification for Treatment on an Outpatient Basis)

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

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

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

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

13. Limitation on charges to personal funds:

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

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

            (a) Hair hygiene supplies, comb, brush, etc.
            (b) Razor and shaving cream
            (c) Toothbrush, toothpaste, dental floss.

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

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

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

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

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

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

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

APPENDIX
EXHIBIT A

CMHC EXAMPLE FINANCIAL STATEMENTS

The following is a model financial statement following the AICPA Healthcare Audit Guide, however the appropriate audit guide should be followed. A CMHC 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.

EXHIBIT A

CMHC
BALANCE SHEETS
JUNE 30, XXXXND XXXX

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

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

CMHC

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		
Professional fees		
Other		
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	$	$

The notes to Financial Statements should follow current AICPA statements on Auditing Standards and the Health Care Audit Guide. In addition to those footnote disclosures that fulfill

the accounting profession's reporting standards of adequate disclosure, the Office of Health and Rehabilitation Services requires the following:

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

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

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

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

5. Charity care.

6. Classification of Expenses. (below):

CMHC

SUPPLEMENTARY SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXXX

	Mental Health Services	SA Services	Other Services	Total
REVENUES				
Client service:				
Medicaid capitation, less deferred revenue of $_____				
Medicaid Hospital Alternatives				
Medicaid fee for service				
Rehab Option				
OBRA evaluations				
Other Medicaid				
Medicare partial hospitalization				
Medicare other services				
Client fees				
Private/third-party				
Other contracts				
Net client service revenue				
Government:				
Federal contracts				
Colorado Department of Human Services				

Office of Health and Rehabilitation				
General fund				
Block grant				
Other				
Division of Youth Services				
Total Colorado				
Local government				
County				
Municipal				
School district				
Total Local Government				
Total Government				
Public Support:				
Donated services				
Donated hospital				
Donated Medications				
Donated building space				
Total Public Support				
Other income				
Interest				
Management fees				
Other				
Total other income				
Total revenues	$	$	$	$

CMHC
SUPPLEMENTARY SCHEDULE OF EXPENSES
YEAR ENDED JUNE 30, XXXX

	Mental Health Services	SA Services	Other Services	General and Administration	Total
Personnel:					
Salaries	$	$	$	$	$
Payroll taxes					
Employee benefits					
Temporary and contract labor					
Client:					
Client Salaries					
Payroll taxes & benefits					
External doctors, clinical & hospitals					
Food					
Medical supplies & laboratory					
Medications					
Purchases from other providers					
Supplies and travel					
Occupancy:					
Janitorial					
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					
Vehicles fuel, oil, lease & maintenance					
Other expenses					
Professional fees:					
Audit and accounting					
Legal					
Other consultants					
Donated items:					
Material & building space					
Volunteer services					
Psychiatric Medications					
Hospital care					
Total Expenses	$	$	$	$	$

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.

These BHOs should follow Exhibit B financial statements.

BHO

BALANCE SHEETS
JUNE 30, XXXX AND XXXX

BALANCE SHEETS
JUNE 30, XXXX AND XXXX

ASSETS	XXXX	XXXX
CURRENT ASSETS		
Cash and cash equivalents	$	$
Other contracts receivable		
Prepaid expenses and other		
Total Current Assets		
PROPERTY AND EQUIPMENT, At Cost		
Furniture and fixtures		
Equipment		
Less accumulated depreciation		
OTHER ASSETS		
Deposits		
Organization costs, less accumulated amortization of $_____ XXXX, $_____ XXXX		

LIABILITIES AND NET ASSETS	XXXX	XXXX
CURRENT LIABILITIES		
Accounts payable	$	$
Accrued expenses		
Incurred but not reported		
Deferred revenues		
Other		
Total Liabilities		
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Unrestricted		
Board designated		
Unrestricted		
	$	$

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

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

BHO

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

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

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

BHO

NOTES TO FINANCIAL STATEMENTS
JUNE 30, XXXX AND XXXX

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

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

EXHIBIT C: SUPPLEMENTARY UNIT COST REPORT (CMHC)

Please open the embedded workbook below to find the forms:

Supplementary Cost Report for CMHCs

EXHIBIT D
Related Party Transactions

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

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

MANAGED SERVICE ORGANIZATION

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

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

MANAGED SERVICE ORGANIZATION

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

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

MANAGED SERVICE ORGANIZATION

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

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

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

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

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

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

MANAGED SERVICE ORGANIZATION

SUPPLEMENTAL SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXX2

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

Other			
Total other income			
Total revenues	$	$	$

MANAGED SERVICE ORGANIZATION

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

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

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

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

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

EXHIBIT G:
MEDICAID CAPITATION PROGRAM
A Glossary of Managed Care Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EXHIBIT H:

Fiscal and Statistical Indicators -- Supplementary Audit Schedules
Forms for Behavioral Health Organizations

Please open the embedded workbook below to find the forms:

Supplementary Audit Schedules for BHOs

EXHIBIT I

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			