2020

Behavioral Health Accounting and Auditing Guidelines

COLORADO
Department of Health Care Policy & Financing

COLORADO
Office of Behavioral Health
Department of Human Services

Updated for Fiscal Year Ended

June 30, 2020

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Chapter 1: Overview

PURPOSE

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

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

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

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

- define cost classification and basic cost accounting standards;
- capture cost data for services provided;
- capture utilization for those services with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual, regardless of funding source and/or program;
- capture Relative Value Unit (RVU) weights for services with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual; and
- calculate a base cost per unit of service unique to each center or clinic for RVU-based services provided with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual, regardless of funding source and/or program.
- calculate a cost per day unique to each center or clinic for non-RVU-based residential and inpatient services provided with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the Uniform Service Coding Standards Manual, regardless of funding source and/or program.

APPLICABILITY

These Guidelines are to be observed by providers of behavioral health services under contract, subcontract or general auspices of the Office of Behavioral Health, Colorado Department of Human Services (OBH) and the Colorado Department of Health Care Policy and Financing (HCPF) regardless of the source of the funds (state or federal). Each year, funded providers will file Audited Financial Statements (AFS), per Exhibits A, B and C in the appendix, as well as a Colorado Unit Cost Report, per Exhibit E in the appendix, with OBH and HCPF. All contractors assume responsibility for observance of these Guidelines consistent with underlying agreements and program objectives.

UPDATING THE GUIDELINES

On an annual basis, a committee will convene to evaluate these Guidelines for their applicability to the present circumstances and recommend changes. The committee will consist of representatives from OBH, HCPF, and the funded behavioral health providers. Any changes needed to the Guidelines must be agreed upon and implemented by June 30th for implementation in the new fiscal year. OBH and HCPF, as the grant making and funding entities, will have the final authority in approving updates to the Guidelines to ensure compliance with state and federal guidelines.

SUBMISSION TIMELINE AND DEADLINES

November 30: - Submission by CMHC's of all items included in Exhibit F to Myers & Stauffer.

- HCPF-sponsored audit of Colorado Unit Cost Report for all providers begins.

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

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

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

- Submission by CMHC's of annual audited financial statements and final audited Colorado Unit Cost Report to OBH.

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

Chapter 2: Cost Accounting Standards

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

Standard 1 – Consistency of Costs
Standard 2 – Natural and Functional Classifications
Standard 3 – Direct and Indirect Cost Definitions
Standard 4 – Cost Allocation Methodologies
Standard 5 – Unallowable Costs
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Standard 1: Consistency of Costs

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

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

Standard 2: Natural and Functional Classifications

Applicable accounting standards require maintenance of accounting records that reflect the classification of expenses by both natural and functional categories. Expenses should be coded at the time of initial recording to accomplish both the natural and functional classification. These terms are defined in the AICPA Audit and Accounting Guide, Not-for-Profit Entities (most recent edition) and AICPA Audit and Accounting Guide, Health Care Entities (most recent edition) as:

> *Functional expense classification:* A method of grouping expenses according to the purpose for which costs are incurred. The primary functional classifications are program services and supporting activities. The functional reporting classifications are dependent upon the type of services rendered by the organization.

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

Natural expense classification: A method of classifying expenditures according to the nature of the expense such as salaries and wages, employee benefits, supplies, and purchased services.

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

Total expenses categorized under the natural classifications in the annual audited financial statements must include all independent financial statement auditor adjustments and reconcile to Schedule 1 of the Colorado Unit Cost Report (Exhibit E). All gains and losses on asset sales are to be recorded in accordance with generally accepted accounting principles in both the annual audited financial statements and the Colorado Unit Cost Report.

Standard 3: Direct and Indirect Cost Definitions

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

Direct costs are costs that can be traced directly to a cost center and/or program. In general, costs should be treated as direct to cost centers and/or programs when they are incurred in support of a specific cost center and/or program. This includes both direct service costs, such as salaries and wages for direct service staff, and administrative and operating costs that can be directly attributable to a certain program or service, such as supplies for a specific program.

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

Indirect costs include costs that are not easily assignable to a specific cost center and/or program and are incurred by the organization for a common purpose benefiting the facility as a whole or a range of programs.

Standard 4: Cost Allocation Methodologies

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

Method 1: Direct Assignment
Direct program administrative and operating costs, such as personnel salaries, fringe benefits, contracted costs, and supplies that benefit and can be traced directly to a cost center and/or program should be assigned directly to the benefitting cost center and/or program. All unallowable costs, such as advertising and fines and penalties, should be directly assigned to an "unallowable" cost center/program and are not an allocation of indirect costs.

Method 2: Allocation Across Specific Programs
Costs that directly benefit more than one cost center and/or program should be allocated to the cost centers and/or programs that benefit from them. An example is the operating expense of a building that is used to provide services to clients in multiple programs. Since this is an item of cost traceable to several cost centers and/or programs, it is allocated to the benefiting cost centers and/or programs based on a statistic, such as square footage.

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

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

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

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

- Journal entries in the accounting system supported by contemporaneous time records;
- Service activity logs or unit increments captured during the cost reporting period; or
- Time study for a minimum of four weeks performed during the cost reporting period. Time

study must be based on documented records, reviewed periodically, and adjusted accordingly.

Employees paid in full or in part with federal funds must adhere to Standards For Documentation of Personnel Expenses identified in 2 CFR 200.430. If a provider uses a different methodology to allocate direct service personnel costs based on time spent, supporting documentation must be maintained and made available upon request. Any allocation of costs must reasonably assign costs to the columns based on sound accounting principles.

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

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

These standards for assigning direct costs and allocating direct and indirect costs to cost centers and/or programs are to be used by all providers.

Cost allocations in residential and inpatient facilities:
Proper matching of costs and units must be maintained when categorizing between RVU and non-RVU-based services. Some residential and inpatient facilities incur expenses for both RVU and non-RVU-based services.

In accordance with the instructions for Schedule 1, Columns 4, 5, 6 and 8, the costs of providing encounter-based services without RVU weights and the costs of providing encounter-based services with RVU weights that are combined and billed as a bed day are to be classified under Columns 4, 5, 6 or 8, as appropriate. The RVU-based units that are combined and billed as a bed day are not to be included in Schedule 3 or 3A.

The costs of providing encounter-based services with RVU weights in residential and inpatient facilities that are billed separately from bed days, such as professional services in an inpatient setting (therapy, medication management, evaluations, etc.), are to be classified under Column 3, Encounter-based Services with RVU Weights. The RVU-based units that are billed separately are to be included in Schedule 3 or 3A.

The allocation of costs between RVU and non-RVU-based services provided in a residential or inpatient facility must be based on a reasonable statistic. Documentation to support the allocation basis must be maintained and made available upon request.

Standard 5: Unallowable Costs

Certain costs are unallowable for reimbursement by OBH and HCPF or only allowable in certain situations. The accounting system needs to be established for these costs to be readily identified so they can be segregated from the allowable cost categories. Definitions of these costs, both those that are wholly non-allowable and those that are unallowable in certain situations, are as follows:

Advertising and Public Relations Costs:

The term advertising costs means the costs of advertising media and corollary administrative costs. Advertising media include magazines, newspapers, radio and television, direct mail, exhibits, electronic or computer transmittals, and the like. Unallowable advertising and public relations costs include the following:

- All advertising and public relations costs other than as specified below:
    - The only allowable advertising costs are those which are solely for:
        - The recruitment of personnel;
        - The procurement of goods and services for the performance of a specific contract;
        - The disposal of scrap or surplus materials acquired in the performance of a specific contract except when entities are reimbursed for disposal costs at a predetermined amount; or
        - Program outreach and other specific purposes necessary to meet the

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

Alcoholic Beverages: The cost of alcoholic beverages is unallowable.

Bad Debts: Any losses arising from uncollectible accounts and other claims and related costs are unallowable.

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

Donations and Contributions: The value of contributions and donations made to other organizations or received from other organizations, including cash, property such as material and building space, services such as volunteer services or hospital care, or any in-kind such as donated psychiatric medications, regardless of the recipient, are unallowable.

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

Depreciation: The computation of depreciation or use allowances *will exclude*: (1) The cost of land; (2) Any portion of the cost of buildings and equipment specially funded or donated by the State or Federal Government irrespective of where title was originally vested or where it presently resides; and (3) Any portion of the cost of buildings and equipment contributed

by or for the governmental unit, or a related donor organization, in satisfaction of a matching requirement.

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

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

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

Entertainment Costs: Costs of entertainment, including amusement, diversion, and social activities and any associated costs such as meals, lodging, rentals, transportation, and gratuities are unallowable, except where specific costs that might otherwise be considered entertainment have a programmatic purpose and are authorized either in the approved budget for a contract award or with prior written approval of the awarding agency.

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

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

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

Housing and Personal Living Expenses: Costs of housing (e.g., depreciation, maintenance, utilities, furnishings, rent, etc.), housing allowances and personal living expenses for/of the organization's officers are unallowable as fringe benefit or indirect costs regardless of whether

the cost is reported as taxable income to the employees. The term "officers" includes current and past officers and employees.

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

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

- They are necessary to meet fluctuations in workload; or
- Although not necessary to meet fluctuations in workload, they were necessary when acquired and are now idle because of changes in program requirements efforts to achieve more economical operations, reorganization, termination, or other causes which could not have been reasonably foreseen. Under the exception stated in this subparagraph, costs of idle facilities are allowable for:
    - A reasonable period of time, ordinarily not to exceed one year, depending on the initiative taken to use, lease, or dispose of such facilities; and
    - The idle facility capital cost does not exceed 10% of the facility's total capital cost. Capital costs are defined as facility depreciation, facility interest and or facility lease payments.

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

Interest related to the construction or purchase of a facility is allowable unless the debt arrangement exceeds $1 million dollars and the initial equity contribution was less than 25%. This situation requires a calculation of cash flows to determine the amount that is unallowable. See 2 CFR 200.449 (c)(7)(ii) for more detail at http://www.ecfr.gov/cgi-bin/text-idx?SID=700fa613fba6b28f8072084a0d76b3b4&node=se2.1.200_1449&rgn=div8

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

Less-than-arm's-length Transactions: All costs under "less-than-arm's-length" transactions are allowable only up to the amount of actual costs incurred by the non-Federal entity. Costs in excess of the originating related party's actual costs of providing services are not allowed. For this purpose, a less-than-arm's-length transaction is one under which one party to the transaction is able to control or substantially influence the actions of the other or fall under common control. Transactions defined as "less-than-arm's-length" for the purpose of calculating the base unit cost may differ from those identified as related party transactions in the non-Federal entity's audited financial statements. Examples of less-than-arm's-length transactions include leases, management agreements, or administrative service agreements

between a parent and subsidiary or commonly-owned subsidiaries.

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

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

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

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

Personal Gifts: Costs of personal gifts are unallowable.

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

Rental Costs of Real Property and Equipment:
(a) Subject to the limitations described below, rental costs are allowable to the extent that the rates are reasonable in light of such factors as: rental costs of comparable property, if any; market conditions in the area; alternatives available; and the type, life expectancy, condition, and value of the property leased. Rental arrangements should be reviewed periodically to determine if circumstances have changed and other options are available.

(b) Rental costs under "sale and lease back" arrangements are allowable only up to the amount that would be allowed had the non-Federal entity continued to own the property. This amount would include expenses such as depreciation, maintenance, taxes, and insurance.

(c) Rental costs under "less-than-arm's-length" leases are allowable only up to the amount as

explained in paragraph (b) of this section. For this purpose, a less-than-arm's-length lease is one under which one party to the lease agreement is able to control or substantially influence the actions of the other.

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

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

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

Standard 6: Rules for Recipients of Block Grant Funds

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

A. Activities Allowed or Unallowed

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

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

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

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

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

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

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

A. Activities Allowed or Unallowed

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

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

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

4. Grant funds shall not be used to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or any other facility, or purchase major medical equipment. The Secretary may provide a waiver of the restriction for the construction of a new facility or rehabilitation of an existing facility, but not for land acquisition (42 USC 300x-31(a); 45 CFR sections 96.135(a)(3) and (d)).

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

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

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

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

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

Standard 7: Reporting Period

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

These cost accounting standards guide the accounting of costs in the Annual Audited Financial Statements (Exhibits A, B and C) and the CMHC Colorado Unit Cost Report (Exhibit E). Please refer to Chapters 3 and 4 for specific instructions on completing these forms. Note that the Annual Audited Financial Statements, including all auditor adjustments, must reconcile to the CMHC Colorado Unit Cost Report.

Chapter 3: Auditing and Financial Reporting Guidelines

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

Community Mental Health Centers (CMHC)

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

Managed Service Organizations (MSO)

Agencies contracting directly with the State of Colorado are referred to as Managed Service Organizations (MSOs). Agencies selling services to MSOs are referred to as Sub-recipients.

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

Internal Controls

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

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

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

Expense Classifications and Allocation Methodologies

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

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

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

Expense Description		Used for
Personnel Costs		
	Salaries, Payroll Taxes and Employee Benefits	Salaries paid to regular employees, full or part-time, and temporary employees other than consultants and others engaged on an individual contract basis and the related taxes and costs of employee health insurance and retirement benefit plans.
Client Related Costs		
	Client Salaries, Taxes and Benefits	Salaries paid to clients and related taxes and benefits
	External Doctors, Clinics and Hospitals	Amounts paid to external doctors, clinics and hospitals for services to clients
	Client Food	Cost of food provided to clients
	Medical Supplies and Laboratory	Cost of medical supplies and laboratory fees
	Medications	Cost of medications used by clients
	Purchases from Other Providers	Expenses for purchasing services from other providers that provide the same or similar services

Expense Description		Used for
	Supplies and Travel	Cost of supplies used by clients (i.e. recreation and craft materials) and the cost of transporting clients to and from programs
Occupancy Costs		
	Janitorial	Expenses resulting from an agency's occupancy and use of owned, rented, leased or donated building and offices
	Maintenance and Supplies	
	Property Insurance	
	Rent	
	Real Estate Taxes	
	Utilities	
Operating Costs		
	Dues, Fees, Licenses and Subscriptions	Costs of memberships in other organizations, publications, bank and collection fees, licenses, etc.
	Equipment Rentals and Maintenance	Costs of renting or leasing and maintaining equipment such as computers, office equipment and program equipment
	Insurance	Costs, paid or accrued, of premiums for insurance contracts to reimburse the organization for revenue or property loss caused by various types of events over which the agency has no control (i.e., fire, theft, content and liability)
	Interest	Costs of borrowing money (subject to restrictions noted in Standard 5: Unallowable Costs)
	Office Supplies	Costs of office supplies and low cost furniture and equipment that is not capitalized
	Postage, Printing and Copying Costs	Costs of postage, internal and external printing and copying costs for such items as brochures, manuals and pictures
	Telephone	Costs of telephone and other electronic communication expenses

Expense Description		Used for
	Travel, Conferences and Staff Development	Expenses of staff travel including mileage allowances, hotel, meals and incidental expenses and expenses associated with providing formal internal and external staff development programs including training classes, meeting space and equipment rentals
	Automobile Expenses	Costs of agency-owned or leased vehicles
Depreciation and Amortization		Depreciation and amortization expense for depreciable assets owned by the agency
Provision for Uncollectible Accounts		Amount of estimated uncollectible portions of accounts receivable *
Professional Fees		Fees and expenses of professional practitioners and consultants who are not employees of the agency and are engaged for specified services on a fee or other individual contract basis
Donations (Donated In-Kind or Cash)		Value of donations made to other organizations or received from other organizations for cash, material and building space, volunteer services, hospital care, and donated psychiatric medications

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

General Auditing Guidelines

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

The actual conduct of the financial audit is governed by Generally Accepted Auditing Standards and other authoritative pronouncements of the profession particularly the AICPA Audit and Accounting Guide, Health Care Entities, as well as the requirements contained elsewhere in this

guide.

OBH and HCPF require that the independent auditor of the CMHCs' financial statements have current AICPA peer review documents on file. The CMHCs must follow the cost accounting and auditing guidelines outlined in OMB 2 CFR 200, Audits of States, Local Governments, and Non-Profit Organizations. The auditors, in conjunction with the organization, are responsible for determining if the organization is subject to 2 CFR 200 Subpart F audit requirements. If applicable, the auditor will be required to follow the Generally Accepted Governmental Audit Standards (GAGAS) in the conduct of the audit. The entity and its auditor will still be required to provide the supplemental information and related accountants' reports as contained in the example financial statements included herein. OBH/HCPF guidelines, as outlined in this section, assume that the auditor will follow those standards and pronouncements.

Financial Statement Auditing Guidelines

The annual audited financial statements are the primary documents used to calculate the organization's service costs. The audits of these financial statements provide credibility to the reimbursement system presented to the legislature, as financial statement information is subjected to independent audit procedures including testing of controls and the validity of supporting documentation. Required financial statements are presented in Exhibits A, B and C; however, if changes are made to the AICPA Audit and Accounting Guide, Health Care Entities, conforming changes must be made to the financial statement presentation.

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

Management Letter

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

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

Care should be exercised by the auditor to ensure that management letter comments which represent findings to be reported under the requirements of OMB 2 CFR 200 Subpart F are appropriately included in the applicable report.

Chapter 4: Instructions for the Colorado Unit Cost Report

In addition to completing annual audited financial statements (Exhibits A, B and C), the CMHCs must also complete a Colorado Unit Cost Report (Exhibit E) that requires detailed reporting of expenses and utilization. These schedules capture the data necessary to calculate the base unit cost and per diem costs for each CMHC which are used in the service pricing methodologies of HCPF and OBH.

Schedule 1: Trial Balance of Expenses

Trial Balance of Expenses by Functional Classification

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

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

Column 2 - Indirect (Not Traceable to Direct Cost Centers and/or Programs):
The Executive Director, CFO, Accounting, IT, and other administrative functions essential to the operation of the organization are indirect staff. Expenses that are not directly traceable to a cost center and/or program will be reported discretely in this column and allocated out to columns 3 through 9.

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

Column 3a – Integration Encounter-based Services* with RVU Weights:
For costs related to the provision of outpatient services that are integrated with physical healthcare services which generate encounters with approved CPT/HCPCS billing codes and

have established RVU weights assigned to them.

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

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

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

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

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

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

issues drive the need for consultation, which is done through personal communication. As professionals have more opportunity to share patients, they have a better basic understanding of each other's roles.

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

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

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

The costs of providing encounter-based services with RVU weights in an ATU that are combined and billed as a bed day are to be classified under Column 4.

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

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

Column 6 - Encounter-based Residential Services without RVU Weights:
For costs related to the provision of residential services in a 24 hour supervised residential program which generate encounters, but do not have established RVU weights assigned to them.

The costs of providing encounter-based services with RVU weights in a 24 hour supervised residential program that are combined and billed as a bed day are to be classified under Column 6.
The costs of providing encounter-based services with RVU weights that are billed separately

from bed days, such as professional services in a residential setting (therapy, medication management, evaluations, etc.), are to be classified under Column 3, Encounter-based Services with RVU Weights.

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

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

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

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

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

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

Column 8 – Detox Services without RVU weights:

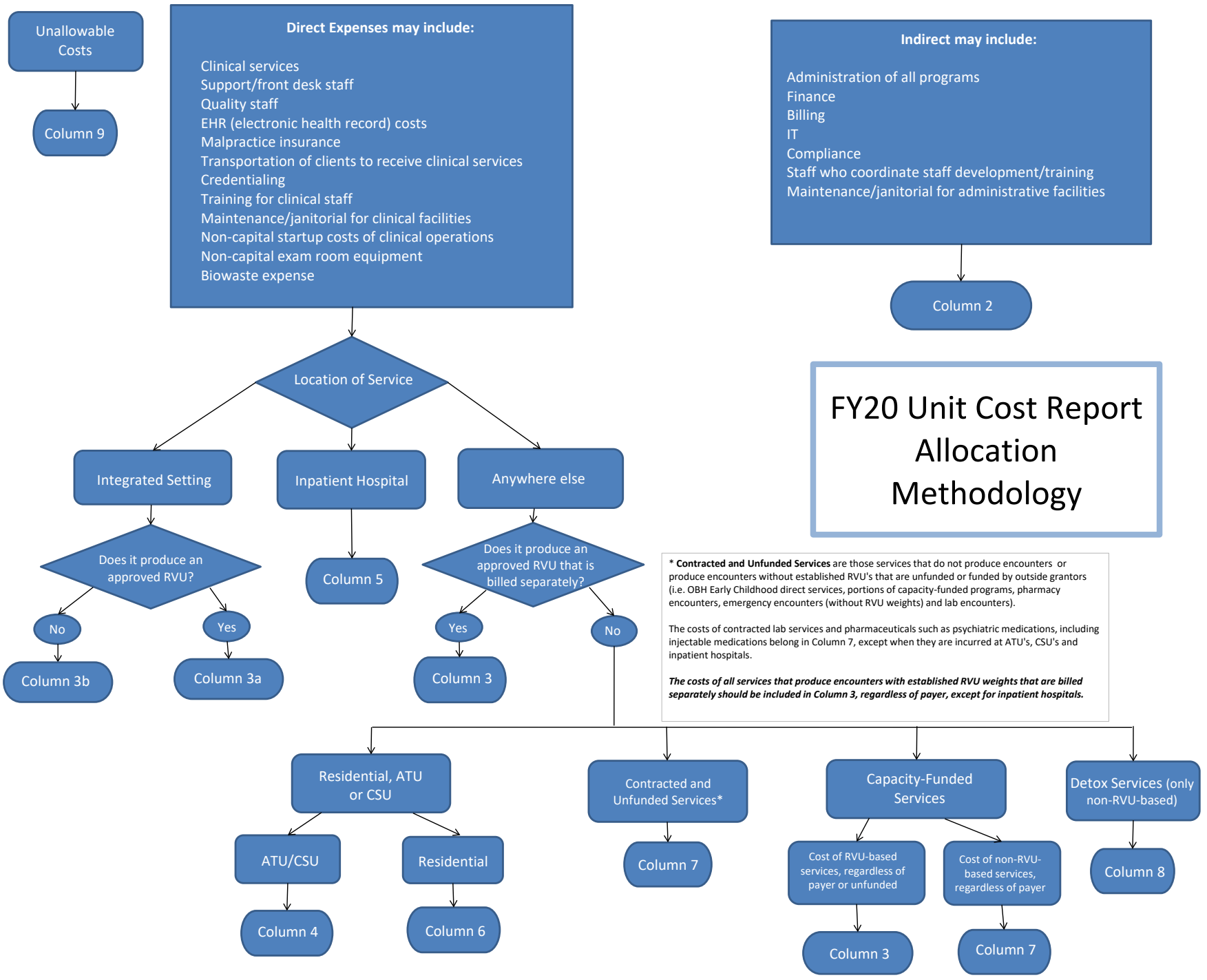
For costs related to the provision of detox services that generate encounters without RVU weights and that do not generate encounters.

Column 9 - Unallowable costs:

For all costs that are identified as unallowable as detailed in Chapter 2.

Column 10 – Total:

This is a summation column (cross totaling columns 2 through 9), no data entry required.


Unallowable Costs
Column 9
Direct Expenses may include:
Clinical services
Support/front desk staff
Quality staff
EHR (electronic health record) costs
Malpractice insurance
Transportation of clients to receive clinical services
Credentialing
Training for clinical staff
Maintenance/janitorial for clinical facilities
Non-capital startup costs of clinical operations
Non-capital exam room equipment
Biowaste expense
Indirect may include:
Administration of all programs
Finance
Billing
IT
Compliance
Staff who coordinate staff development/training
Maintenance/janitorial for administrative facilities
Column 2
FY20 Unit Cost Report Allocation Methodology
Location of Service
Integrated Setting
Inpatient Hospital
Anywhere else
Does it produce an approved RVU?
No
Yes
Column 3b
Column 3a
Column 5
Does it produce an approved RVU that is billed separately?
Yes
No
Column 3
* Contracted and Unfunded Services are those services that do not produce encounters or produce encounters without established RVU's that are unfunded or funded by outside grantors (i.e. OBH Early Childhood direct services, portions of capacity-funded programs, pharmacy encounters, emergency encounters (without RVU weights) and lab encounters).
The costs of contracted lab services and pharmaceuticals such as psychiatric medications, including injectable medications belong in Column 7, except when they are incurred at ATU's, CSU's and inpatient hospitals.
The costs of all services that produce encounters with established RVU weights that are billed separately should be included in Column 3, regardless of payer, except for inpatient hospitals.
Residential, ATU or CSU
ATU/CSU
Residential
Column 4
Column 6
Contracted and Unfunded Services*
Column 7
Capacity-Funded Services
Cost of RVU-based services, regardless of payer or unfunded
Cost of non-RVU-based services, regardless of payer
Column 3
Column 7
Detox Services (only non-RVU-based)
Column 8

Trial Balance of Expenses by Natural Classification

Schedule 1 records the trial balance for the provider at the end of the reporting period. The costs reported on Schedule 1 must come directly from the provider's trial balance and any auditor adjustments that have not been included in the provider's trial balance, which includes all activities conducted by the reporting entity. The standard preprinted line numbers and column descriptions cannot be changed or modified by the provider.

Line 1 – Total Direct Program Staff FTE and Salaries:

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

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

Line 2 – Total Administrative Staff FTE and Salaries:

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

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

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

Line 3 – Total Personnel

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

Lines 4 to 10 – Natural Classification of Expenses:

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

- Providers should report costs which cannot be allocated directly to a direct service cost center and/or program and are allowable per Chapter 2, Standard 5 (indirect expenses only) in column 2 by the appropriate line definition. (See Chapter 4 for definitions).
- For column 9, Unallowable Costs, these costs are accumulated by natural classification (See Chapter 4 for definitions).
- For columns 3 through 8, the provider should report all costs that are

charged or allocated directly to the direct service cost centers and/or programs that have not been recorded in columns 2 or 9. The costs should be classified by the appropriate line definition.

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

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

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

Line 12 – Indirect Cost Allocation:

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

Cost allocations for line 12, across columns 3 through 9, must be made using a reasonable statistic based on sound methodologies that results in the allocation of costs to all columns containing direct expense, including column 9, Unallowable Costs. Multi-step allocations are acceptable, as long as the resulting allocation conforms to the requirement to allocate indirect cost to all columns. Modification of allocation bases in order to calculate the allocation statistics is not allowed (i.e. if direct cost is selected as the allocation basis, the direct cost amounts reported in each column cannot be increased or decreased in order to calculate the allocation percentage for that column).

This line will total to $0 in column 10 as it is an allocation to offset the amount in line 12, column 2.

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

Line 13 – Total Cost:

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

Note: Line 1 and Lines 3 through 11 (across columns 2 through 9), as summed in column 10 (Total Cost), should reconcile to the natural expense classification line items in the expenses shown on the CMHC's Statement of Operations in the organization's audited financial statements, including all auditor adjustments.

Line 14 – Unduplicated Client Count:

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

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

Line 15 – Cost per Unduplicated Client

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

Schedule 2: Supplemental Schedule for Column 7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Column 1 – Total Units

Providers should report all *encounterable units of service, with or without an RVU weight,* provided in a Non-Facility setting by the CPT/HCPCS codes listed on Schedule 3. Service definitions for the CPT/HCPCS codes are in the column labeled "Description." Units reported

must be of the same nature and time period as defined in this column. The Total line automatically calculates the total units. The provider should not enter any data in this line.

Column 2- Total Relative Value Units
All rows in this column are calculated automatically. The calculation is the column heading "Non-facility RVU Weight" X the number of units in Column 1.

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

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

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

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

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

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

Column 1 – Total Units
Providers should report all *encounterable units of service, with or without an RVU weight,* provided in a Facility setting by the CPT/HCPCS codes listed on Schedule 3A. Service definitions for the CPT/HCPCS codes are in the column labeled "Description." Units reported must be of the same nature and time period as defined in this column. The Total line automatically calculates the total units. The provider should not enter any data in this line.

Column 2- Total Relative Value Units
All rows in this column are calculated automatically. The calculation is the Column heading "Facility RVU Weight" X the number of units in Column 1.

Schedule 4: Base Unit Cost Calculation

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

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

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

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

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

Schedule 5: Residential/Inpatient Services Detail

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

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

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

Column 3 - License Type:
Indicate the license under which each facility is registered.

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

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

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

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

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

Column 9 - Room and Board:
Room and board expenses per residential facility (inpatient facilities are excluded) should be entered in Column 9. The term "room" means shelter type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals a day or any other full nutritional regimen.

Column 10 - Cost Per Day – Room & Board:
The total expenses from Column 9 divided by Column 5 Census Days.

Column 11 - Total Expenses less Room and Board:
The total expenses from Column 7 less the total expenses from Column 9.

Column 12 - Cost Per Day – Services:
The total expenses from Column 11 divided by Column 5 Census Days.

Exhibit A: CMHC Example Financial Statements

The following is a model financial statement following the AICPA Audit and Accounting Guide, Health Care Entities; however, the appropriate audit guide should be followed.

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

CMHC

BALANCE SHEETS
JUNE 30, XXXX and XXXX

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

CMHC

BALANCE SHEETS
JUNE 30, XXXX and XXXX

LIABILITIES AND NET ASSETS	XXXX	XXXX
CURRENT LIABILITIES		
Notes payable	$	$
Current maturities of long-term debt		
Incurred but not reported		
Accrued expenses		
Estimated retroactive adjustments - third party payers		
Deferred revenue		
Other		
Total Current Liabilities		
LONG-TERM DEBT		
Total Liabilities		
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Without donor restrictions		
With donor restrictions		
	$	$

CMHC

STATEMENTS OF OPERATIONS
YEARS ENDED JUNE 30, XXXX AND XXXX

	XXXX	XXXX
REVENUES AND GAINS		
Net client, Medicaid, Medicaid capitation, Medicare, insurance, third party and other service revenue	$	$
State revenue		
Public support		
Other		
EXPENSES		
Personnel		
Client related		
Occupancy		
Operating		
Depreciation and Amortization		
Provision for Uncollectible Accounts		
Professional fees		
Donated items		
OPERATING INCOME		
OTHER INCOME		
Investment income		
Income from investment in equity investee		
INCREASE (DECREASE) IN 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		
RESTRICTED NET ASSETS		
Net realized gains (losses) in restricted investments		
Net assets released from restrictions		
Increase (decrease) in restricted net assets		
INCREASE (DECREASE) IN NET ASSETS		
NET ASSETS, BEGINNING OF YEAR		
NET ASSETS, END OF YEAR	$	$

CMHC

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

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

Financial Statement Notes:

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

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

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

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

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

5. Charity care.

Financial Statement Supplemental Schedule:
CMHC

SUPPLEMENTARY SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXXX

REVENUES

Client service:
- Medicaid capitation
- Medicaid Hospital Alternatives
- Medicaid fee for service
- OBRA
- Other Medicaid
- Medicare partial hospitalization
- Medicare other services
- Client fees
- Private/third-party
- Other contracts

Net client service revenue

Government:
- Federal contracts
- Colorado Department of Human Services:
  - Office of Behavioral Health
  - Division of Youth Services
- Total Colorado Dept. of Human Services
- Local government
  - County Municipal
  - School district
- Total Local Government

Total Government

Public Support:
- Donated services
- Donated hospital
- Donated Medications
- Donated building space

Total Public Support

Other income
- Interest
- Management fees
- Other

Total other income

Total revenues

Exhibit B: Not-For-Profit Example Financial Statements

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

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

Not-for-Profit Entity – Statements of Financial Position

Assets:	**Year I**	**Year II**
Cash and cash equivalents	$	$
Account and interest receivable	$	$
Inventories and prepaid expenses	$	$
Contributions receivable	$	$
Short-term investments	$	$
Assets restricted to investment in land, buildings and equipment	$	$
Land, building, and equipment	$	$
Long-term investments	$	$
	$	**$**
Liabilities and Net Assets:		
Accounts payable	$	$
Refundable advance	$	$
Grants payable	$	$
Notes Payable	$	$
Annuity obligations	$	$
Long-term debt	$	$
	$	**$**
Net Assets:		
Without donor restrictions	$	$
With donor restrictions (Note B)	$	$
	$	**$**
Total Liabilities and Net Assets:	**$**	**$**

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

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

Changes in Net Assets Without Donor Restrictions:	
Revenues and gains:	$
Contributions	$
Fees	$
Income on long-term investments (Note E)	$
Other investment income (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Other	$
Total revenues and gains without donor restrictions	$
Net assets released from restrictions (Note D):	$
Satisfaction of program restrictions	$
Satisfactions of equipment acquisition restrictions	$
Expiration of time restrictions	$
Total net assets released from restrictions	$
Total unrestricted revenues, gains, and other support	$
Expenses and losses:	$
Program A	$
Program B	$
Program C	$
Management and general	$
Fund raising	$
Total expenses (Note F)	$
Fire loss	$
Total expenses and losses	$
Increase in unrestricted net assets	**$**
Changes in Restricted Net Assets:	
Contributions	$
Income on long-term investments (Note E)	$
Net unrealized and realized gains on long-term investments (Note E)	$
Actuarial loss on annuity obligations	$
Net assets released from restrictions (Note D)	$
Decrease in restricted net assets	**$**
Increase in Net Assets	**$**
Net Assets at the beginning of year	**$**

Not-for-Profit Entity - Statements of Activities – Format B

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

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

Not-for-Profit Entity - Statement of Activities – Format C (1/2)

Format C reports information in two statements with summary amounts from a statement of revenues, expenses, and other changes in unrestricted net assets (part 1 of 2) articulating with a statement of changes in net assets (part 2 of 2). Alternative formats for the statement of changes in net assets-a single column and a multicolumn- are illustrated. The two statement approaches of Format C focus attention on changes in unrestricted net assets. That format may be preferred by not-for-profit's that view their operating activities as excluding receipts of donor-restricted revenues and gains from contributions and investment income.

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

Not-for-Profit Entity - Statement of Activities – Format C (2/2)

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

Not-for-Profit Entity - Statement of Activities – Format C (2/2) Alternate

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

Exhibit C: Managed Service Organization Example Financial Statements

MANAGED SERVICE ORGANIZATION

BALANCE SHEETS
JUNE 30, XXX2 AND XXX1

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

MANAGED SERVICE ORGANIZATION

BALANCE SHEETS
JUNE 30, XXX2 AND XXX1

LIABILITIES AND NET ASSETS	XXX2	XXX1
CURRENT LIABILITIES		
Notes payable	$	$
Current maturities of long-term debt		
Incurred but not reported		
Accrued expenses		
Estimated retroactive adjustments - third party payers		
Deferred revenue		
Other		
Total Current Liabilities		
LONG-TERM DEBT		
Total Liabilities		
COMMITMENTS AND CONTINGENCIES		
NET ASSETS		
Without donor restrictions		
With donor restrictions		
	$	$

MANAGED SERVICE ORGANIZATION

STATEMENTS OF OPERATIONS
YEARS ENDED JUNE 30, XXX2 AND XXX1

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

MANAGED SERVICE ORGANIZATION

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

	XXX2	XXX1
UNRESTRICTED NET ASSETS		
Excess of revenues over expenses	$	$
Net assets released from restrictions		
Increase (decrease) in unrestricted net assets		
RESTRICTED NET ASSETS		
Net realized gains (losses) in restricted investments		
Net assets released from restrictions		
Increase (decrease) in 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, XXXX AND XXXX

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

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

2. Disclosure of MSO ownership/affiliation with other corporations, foundations, etc., including an explanation of the type of relationship. Disclosure of financial data may be required -- see AICPA Audit and Accounting Guide, Health Care Entities.

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

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

MANAGED SERVICE ORGANIZATION

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

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

Exhibit D: Sub-Recipient of MSO Supplemental Schedules

SUB-RECIPIENT OF MSO
SUPPLEMENTARY SCHEDULE OF REVENUES
YEAR ENDED JUNE 30, XXXX

	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, XXXX

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

Exhibit E: Colorado Unit Cost Report Template

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

Exhibit F: Items to be submitted to Myers & Stauffer by November 30

1. Annual audited financial statements for the cost report period
2. Colorado Unit Cost Report
3. Cost Report Review Questionnaire
4. Working trial balance detailing account balances by program (team) for the cost report period.
5. Crosswalk or grouping schedule identifying where each account and program (team) on the working trial balance is reported on the cost report (e.g. cost report preparation tool).
6. Allocation schedules to illustrate and substantiate the distribution of expenses between multiple functional cost centers on the cost report (if any) and a written narrative to describe the statistics/methodologies used for each allocation.
7. If indirect costs reported on Schedule 1, Column 2 are not allocated to the various other functional cost centers based on cost, submit an allocation schedule to illustrate and substantiate the methodology used to distribute indirect costs to the various other functional cost centers and a written narrative to describe the statistics/methodology used.
8. Allocation schedules to illustrate and substantiate the distribution of expenses between multiple general ledger accounts on the working trial balance (if any) and a written narrative to describe the statistics/methodologies used for each allocation.
9. Summary of units by procedure code to substantiate amounts reported on Schedules 3 and 3A of the cost report.
10. Summary of census days by program to substantiate amounts reported on Schedule 5 of the cost report, if any.
11. Documentation to support revenue received for providing primary care services in an integrated setting, to substantiate amounts reported on Schedule 2B, if any.

Exhibit G: Glossary of Managed Care Terms

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

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

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

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

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

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

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

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

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

Center for Medicare and Medicaid Services (CMS) – The US Government agency

responsible for administering Medicare and Medicaid (formerly Healthcare Financing Authority).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regional Accountable Entity (RAE) – A single regional entity responsible for the duties previously performed by Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs). RAEs are responsible for building networks of providers, monitoring data and coordinating members' physical and behavioral health care.

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

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

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

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

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

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