2025

# Behavioral Health Accounting and Auditing Guidelines

COLORADO
Department of Health Care Policy & Financing

COLORADO
Behavioral Health Administration

**Updated for Fiscal Year Ended**

**June 30, 2025**

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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 State Behavioral Health Services Billing Manual, formally known as 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 State Behavioral Health Services Billing Manual;
    - Calculate a base cost per unit of service unique to each provider for RVU-based services provided with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the State Behavioral Health Services Billing Manual, regardless of funding source and/or program;
    - Calculate a cost per day unique to each provider for residential and inpatient services provided with Current Procedural Technology/Healthcare Common Procedural Coding System (CPT/HCPCS) codes that are included in the State

Behavioral Health Services Billing Manual, regardless of funding source and/or program; and

- Calculate a prospective payment system (PPS) encounter rate for services included in the PPS methodology.

## Applicability

These Guidelines are to be observed by comprehensive providers of behavioral health services under contract, subcontract or general auspices of the Colorado Behavioral Health Administration (BHA) and the Colorado Department of Health Care Policy and Financing (HCPF) regardless of the source of the funds (state or federal). Each year, comprehensive providers must file Audited Financial Statements (AFS), as well as a Colorado Comprehensive Provider Cost Report, per Exhibit A in the appendix, with BHA 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 behavioral health administrative service organizations, managed care entities, behavioral health safety net providers, independent auditors, actuaries, consumer and family advocates, local government representatives, other state agencies, and other relevant stakeholders. Any changes needed to the Guidelines must be agreed upon and implemented by June 30th for implementation in the new fiscal year. BHA 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.

## Colorado Comprehensive Provider Cost Report Submission Timeline and Deadlines

The timeline below dictates the deadlines for submission, review, and finalization of the Colorado Comprehensive Provider Cost Report. If any of the below dates fall on a weekend or holiday, the due dates will be the following business day. Providers are expected to make every effort to comply with the cost report submission deadline. Providers facing unusual circumstances may request an extension of up to 30 days to submit the cost report. The request for extension must be submitted in writing to HCPF, sufficiently document the reasons for failure to comply with the original due date, and be submitted no less than five business days prior to the original due date. Requests for more than 30-days extension shall be denied.

| | |
|---|---|
| **November 30** | Submission of Colorado Comprehensive Provider Cost Report and all items included in Exhibit B to HCPF and BHA. HCPF-sponsored review of Colorado Comprehensive Provider Cost Report begins. |
| **March 1** | Proposed cost report review findings and adjustments are delivered to providers for their review and consideration. |
| **March 10** | All provider responses to the proposed cost report review findings and adjustments must be received by Colorado Comprehensive Provider Cost Report auditors. |
| **March 15** | HCPF-sponsored review of Colorado Comprehensive Provider Cost Report for all providers concludes. All Colorado Comprehensive Provider Cost Reports are finalized. Submission of annual audited financial statements and final adjusted Colorado Comprehensive Provider Cost Report to BHA. |

## Colorado Comprehensive Provider Cost Report Validation/Acceptance

All nine cost report schedules must be complete and valid before submission. If any of the schedules are incomplete or contain errors, the cost report will be rejected. The validation status of each schedule can be viewed on the "Schedule Validation" tab. Any errors will be clearly described on their respective schedule, providing detailed information on what is wrong and how to correct it. Each provider must provide adequate cost data that is based on their financial and statistical records and is verifiable through adequate supporting documentation provided during the normal course of the review.

# Chapter 2: Cost Accounting Standards

## Purpose

These cost accounting standards guide the accounting of costs for comprehensive behavioral health providers in the annual Audited Financial Statements and the Colorado Comprehensive Provider Cost Report. They are designed to promote uniformity and consistency in cost accounting and cost reporting methods along with adequate cost accounting records for comprehensive behavioral health service operations.

**Standard 1** – Consistency of Costs
**Standard 2** – Natural and Functional Classifications
**Standard 3** – Direct and Indirect Cost Definitions
**Standard 4** – Cost Allocation Methodologies
**Standard 5** – Unallowable Costs
**Standard 6** – Reporting Period

## Standard 1: Consistency of Costs

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

Reasonable documentation of information trails is required to permit tracking of classified costs to the reported actual costs. Comparative reports of historical costs of operations, programs and services also require adherence to the same rules of consistency. Providers are required to report data uniformly, which helps to measure relative efficiency of providers, ensure services are provided equitably across the state, and evaluate effectiveness of programs. These standards will provide BHA, HCPF, and the comprehensive 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 Comprehensive Provider Cost Report (described in Chapter 3).

**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 defined by the rows on Schedule 1 of the Colorado Comprehensive Provider Cost Report (described in Chapter 3).

Total expenses on the Colorado Comprehensive Provider Cost Report must include all independent financial statement auditor adjustments and reconcile to total expenses per the Audited Financial Statements. All gains and losses on asset sales are to be recorded in accordance with generally accepted accounting principles. Expense categories must be consistent between the Colorado Comprehensive Provider Cost Report and the annual Audited Financial Statements and are more specific than generally accepted accounting principles, as follows:

- Personnel
- Contracted Personnel
- Client
- Information Technology
- Occupancy
- Operating

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

| Expense Description | | Used for |
|---|---|---|
| **Personnel Costs** | | |
| | Direct client service personnel salaries | Salaries, wages, and bonuses paid to clinical and direct care staff, full or part-time, permanent or temporary. |
| | Operations personnel salaries | Salaries, wages, and bonuses paid to all other staff not included as direct client service personnel, full or part-time, permanent or temporary. |

| Expense Description | | Used for |
|---|---|---|
| | Other employee-related non-wage, payroll taxes and employee benefits | The payroll taxes and costs of employee health insurance, retirement benefit plans, and other employee benefit expenses for all employees. The other costs of recruiting and employing personnel. |
| **Contracted Personnel Costs** | | |
| | Consultants, Contracted Personnel | The costs associated with consultants or contracted personnel, or the entities responsible for the provision of behavioral health services. |
| **Client 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 non-behavioral health 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 |
| | 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 |
| **Information Technology Costs** | | |
| | EHR, Telecomm, Software, Hardware | The costs associated with the electronic health records (EHR), including maintenance, support, and equipment, as well as software upgrades and improvements. The costs associated with telecommunication and information technology functions. |
| **Occupancy Costs** | | |
| | Janitorial | Expenses resulting from an agency's occupancy and use of owned, rented, leased or donated building and offices |
| | Maintenance and | |

| Expense Description | | Used for |
|---|---|---|
| | Supplies | |
| | Property Insurance | |
| | Interest - Building | |
| | 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 |
| | 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 |

## 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

**For 2025-26 BHA community mental health services contractors:** 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, the costs of providing encounter-based services with RVU weights that are:

- Combined and billed as a bed day are to be classified under Column 4. The RVU-based units that are combined and billed as a bed day are not to be included in Schedule 4.
- 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. The RVU-based units that are billed separately are to be included in Schedule 4.

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.

**For all comprehensive providers:** Proper matching of costs and encounters must be maintained when categorizing between PPS and non-PPS services. The allocation of costs between PPS and non-PPS services 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 BHA and HCPF or are 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 detailed below.

### 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.

The only allowable advertising costs are:

- Costs for the recruitment of personnel;
- Costs for the procurement of goods and services for the performance of a specific contract;
- Costs related to 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
- Costs for program outreach and other specific purposes necessary to meet the requirements of a specific contract.

The only allowable public relations costs are:

- Costs explicitly 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.

Unallowable advertising and public relations costs include the following:

- 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.
- All other advertising and public relations costs unless specified as allowable above.

## 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, the purchase of tickets or tables at fundraising events for other providers, 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.

## Direct Salary in Excess of Limit

The direct salary amounts for the five highest-paid non-clinical employees will be subject to an annually-established limit. The limitation is determined annually by HCPF and BHA and can be found on the following website: https://hcpf.colorado.gov/behavioral-health-rate-reform. Direct salary amounts for those individuals must be identified on Schedule 1A of the Colorado Comprehensive Provider Cost Report; amounts in excess of the limit will be automatically calculated on Schedule 1A and automatically reclassified to Unallowable on Schedule 1. For purposes of this calculation, direct salary includes wages and bonus, but does not include other compensation such as company-sponsored vehicles. If an individual serves in a dual clinical and non-clinical capacity, only the non-clinical portion of their direct salary will be subject to this limitation; the calculation of the clinical portion of direct salary should be documented and based on reasonable allocation methods that appropriately apportions costs. Schedule 1A must be used to document and calculate the excess non-clinical direct salaries paid during the cost reporting period; it is not appropriate to remove the excess amounts through mechanisms outside of Schedule 1A or off the cost report.

## 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. Related party transactions should be identified on Schedule 1C of the Colorado Comprehensive Provider Cost Report; amounts in excess of the actual cost will be automatically calculated on Schedule 1C and automatically reclassified to Unallowable on Schedule 1.

## Lobbying

Lobbying costs, including membership fees in trade organizations that employ lobbyists, are unallowable except for costs of 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 client population of the provider (i.e. Medicaid or Indigent as defined by BHA) 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. Costs related to severance pay paid in exchange for, or in association with, the signing of non-disclosure agreements 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: Reporting Period

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

# Chapter 3: Instructions for the Colorado Comprehensive Provider Cost Report

## Purpose

In addition to completing annual audited financial statements, the providers must also complete a Colorado Comprehensive Provider Cost Report (Exhibit A) that requires detailed reporting of revenues, expenses, and utilization. These schedules capture the data necessary to calculate the base unit cost and per diem costs for each provider which are used in the service pricing methodologies of HCPF and BHA.

## Schedule 1: Expenses

### 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 and allow for assignment or allocation of costs to the appropriate functional columns on the Colorado Comprehensive Provider 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 Comprehensive Provider 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. An FTE is based on annual number of hours worked (2,080 hours).

#### *Column 2 – Indirect (Not Traceable to Direct Cost Centers and/or Programs)*

The costs associated with 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 discreetly in this column and allocated out to the remaining columns.

### *Column 3 – Encounter-based Services with RVU Weights and All Integration Services*

The costs related to the provision of outpatient services which generate encounters with approved CPT/HCPCS billing codes and have established RVU weights assigned to them, and the costs related to the provision of services integrated with physical healthcare services. Column 3 should not include costs of any RVU services that are provided in an inpatient hospital setting, as these should be included in Column 4 (Per Diem Inpatient Services and Residential Services without RVU Weights).

### *Column 4 – Per Diem Inpatient Services and Residential Services without RVU Weights*

| | |
|---|---|
| Apartments: | For costs of providing encounter-based services without RVU weights or non-encounter bases services in an apartment setting. |
| ATU or CSU: | 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.<br><br>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. |
| Inpatient Hospital: | For all costs of providing inpatient services with and without RVU weights in a hospital setting, including labs and medications. |
| Residential: | For costs related to the provision of residential services in a 24 hour supervised residential program which generate encounters, but do not have established RVU weights assigned to them. These residential services are provided in Short-Term Residential Treatment Facilities, Long- Term Residential Treatment Facilities, or Acute Treatment Facilities. 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.<br><br>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. |

| | |
|---|---|
| Withdrawal Management: | For costs related to the provision of withdrawal management (formerly known as detox) services that generate encounters without RVU weights and that do not generate encounters. This includes 3.2 clinically managed withdrawal management and 3.7 medically monitored withdrawal management. |

### *Column 5 – Other Encounter-Based Services without RVU Weights and Other Non-Encounter-Based Services*

The costs of encounter-based services that do not have established RVU weights assigned to them such as Early Childhood direct services, some capacity-funded programs, pharmacy encounters, emergency encounters (without RVU weights) and lab encounters not included in Column 4.

Also, the 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.

The direct costs of contracted lab services and pharmaceuticals such as psychiatric medications (including injectable medications) not included in Column 4. These costs should be distinctly identified in the accounting records (i.e. recorded in their own general ledger accounts) in order to allow for proper cost reporting.

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 provider was not reimbursed) or any other payer should be included in Column 3.

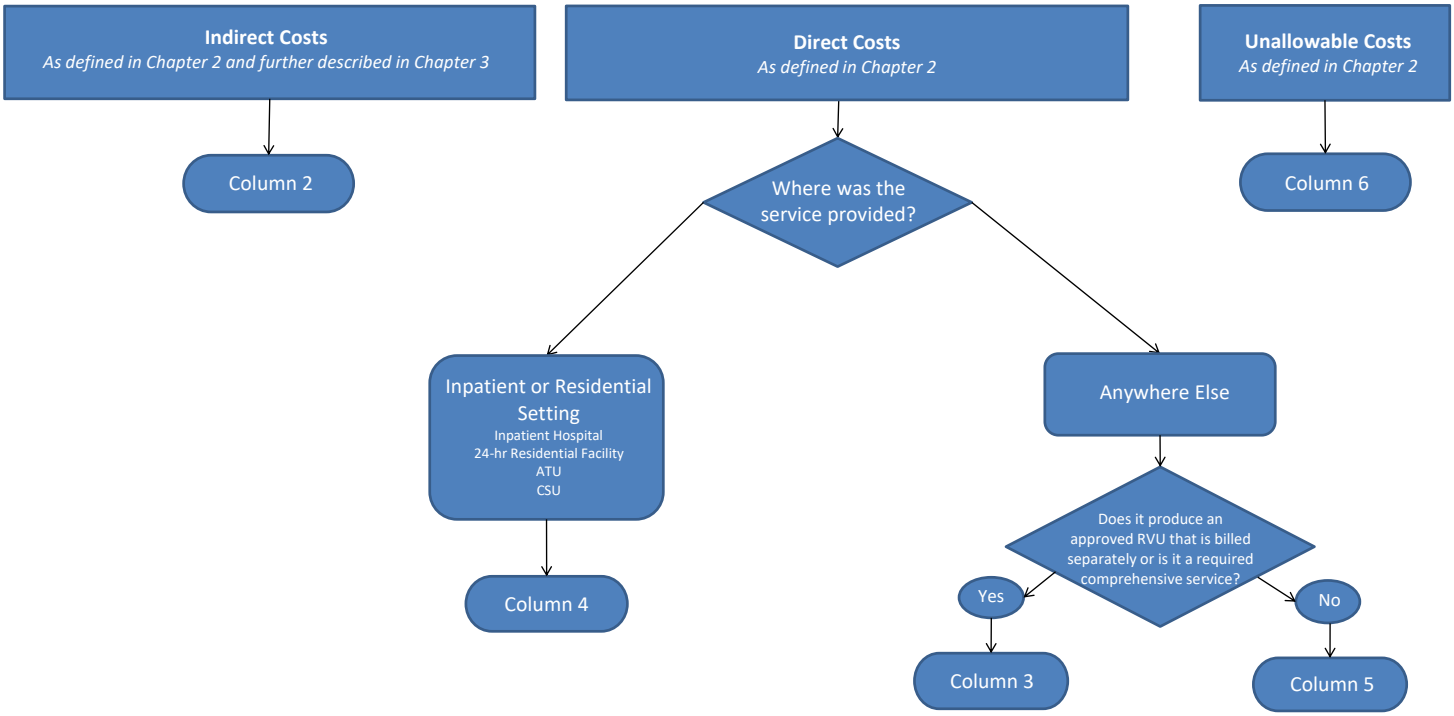
### *Column 6 – Unallowable*

The costs identified as unallowable per Chapter 2 Standard 5.

### *Column 7 – Total*

This column automatically sums all previous columns containing cost.

# FY25 Comprehensive Provider Cost Report Allocation Methodology




* **Contracted and Unfunded Services** are those services that do not produce encounters or produce encounters without established RVUs that are unfunded or funded by outside grantors (i.e. 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 5, except when they are incurred at ATUs, CSUs 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.***

## 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.

### DIRECT CLIENT SERVICE PERSONNEL COSTS

This section contains the costs for the clinical and direct care staff reported in all functional cost centers and/or programs.

#### *Line 1 – Clinical, Licensed Physicians*

The salary, bonus, and commissions for medical doctors (MDs) and psychiatrists operating in a direct client service role (full time, part time, and temporarily), not including amounts paid to consultants or others engaged on an individual contract basis. This line includes the following service providers from the State Behavioral Health Services Billing Manual:

- Psychiatrist

#### *Line 2 – Clinical, Licensed Non-Physicians*

The salary, bonus, and commissions for all licensed clinical staff operating in a direct client service role (full time, part time, and temporarily), not including amounts paid to MDs and psychiatrists, or to consultants or others engaged on an individual contract basis. This line includes the following service providers from the State Behavioral Health Services Billing Manual:

- Licensed Addiction Counselor (LAC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Licensed Psychologist
- Physician Assistant (PA)
- Professional Nurses

#### *Line 3 – Other Clinical or Direct Client Service (BS, Peers, Case Mgmt, etc.)*

The salary, bonus, and commissions for all other staff operating in a direct client service role, such as employees serving as peers, case managers, or who otherwise provide direct client services under the 1915(b)(3) Waiver Program (termed "b3 services" herein). This line includes the following service providers from the State Behavioral Health Services Billing Manual:

- Bachelor's Degree Provider
- Certified Addiction Specialist (CAS)
- Certified Addiction Technician (CAT)
- Certified Prevention Specialist
- Intern (Clinical)
- Peer Specialist (PS)
- Qualified Medication Administration Person (QMAP)
- Unlicensed Doctorate (PhD, PsyD, EdD)
- Unlicensed Master's Degree Provider

### *Line 4 – Direct Client Service Personnel Total*

This line automatically sums the costs reported in Lines 1 through 3.

## OPERATIONS PERSONNEL COSTS

This section contains the costs for all other staff, including executive and administrative staff who are not directly assignable to a cost center and/or program.

### *Line 5 – Executive Leadership*

The salary, bonus, and commissions for executive management employees serving in non-clinical roles, such as the Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, and Chief Information Officer.

### *Line 6 – Other Operations Personnel*

The salary, bonus, and commissions for all other administrative personnel and non-clinical staff not included in any previous lines.

### *Line 7 – Operations Personnel Total*

This line automatically sums the costs reported in Lines 5 and 6.

## DIRECT SALARY LIMITATIONS

### *Line 8 – Excess Salary Above Limit*

This automatically pulls the total by column from the calculation on Schedule 1A, Non-Clinical Direct Salary Limit, and reclassifies amounts for Columns 2 through 5 into Column 6, Unallowable. No data input is necessary here.

### *Line 9 – Total Excess Salary Above Limit*

This automatically pulls the amount reported in the previous line.

### OTHER EMPLOYEE-RELATED COSTS

#### *Line 10 – Employee Recruitment*

The costs associated with the recruitment of personnel, including employment advertising and online search tools.

#### *Line 11 – Benefits and Payroll Taxes*

The costs associated with employee benefits (such as worker's compensation insurance, unemployment insurance, employee health insurance, and retirement benefits) and payroll-related taxes for all employees.

#### *Line 12 – Other Employee-Related*

All other costs associated with the employment of personnel that have not been included in previous lines or not applicable to those identified as Operating Costs, below.

#### *Line 13 – Other Employee-Related Total*

This line automatically sums the costs reported in Lines 10 through 12.

### TOTAL EMPLOYEE COSTS

#### *Line 14 – Total Employee Costs*

This line automatically sums the costs reported in Lines 4, 7, 9, and 13.

### CONTRACTED PERSONNEL COSTS

#### *Line 15 – Clinicians or Clinical Services Contracted Personnel*

The costs associated with consultants or others engaged on an individual contract basis to perform direct client service.

#### *Line 16 – Other Contracted Personnel*

The costs associated with all other non-clinical contracted personnel not identified as Operating Costs, below.

#### *Line 17 – Partner Organizations*

The costs associated with payments to other entities responsible for the provision of essential behavioral health services to clients on behalf of the reporting entity.

#### *Line 18 – Contracted Personnel Total*

This line automatically sums the costs reported in Lines 15 through 17.

### TOTAL PERSONNEL COSTS

#### *Line 19 – Total Personnel Costs*

This line automatically sums the costs reported in Lines 14 and 18.

## CLIENT COSTS

### *Line 20 – Technology Software, Licensing, and Equipment for Use by Clients*

The costs associated with technologies and software used by, given to, or sold to clients, including the cost of software, hardware, licenses, cell phones, tablets, computers, and related equipment.

### *Line 21 – Client Transportation*

The costs associated with transporting clients, including internal and external drivers, contracted secure and unsecure transport, fleet and fleet management. All client transportation costs associated with related parties should be included here and on Schedule 1C, Less-Than-Arm's-Length (Related Party) Transactions; excess related party expense above cost will be automatically reclassified to Column 6, Unallowable, via Line 55 Excess Related Party Expense Above Actual Cost.

### *Line 22 – Client Food and Drink*

The costs associated with food and drinks provided to clients, including gift cards given to clients for food and drink.

### *Line 23 – Client Education Materials*

The costs associated with the development and production of educational or informational materials for clients, including materials provided via print or electronic format.

### *Line 24 – Client Medications*

The costs of medication administered to clients. This includes the cost of the drugs only, and excludes the costs associated with administering the drug.

### *Line 25 – Client Salaries*

The costs of salaries paid to clients for goods or services provided by the client.

### *Line 26 – Other Client*

All other client-related costs, including (but not limited to):

- External doctors, clinics, and hospitals
- Medical supplies
- Laboratory fees
- Purchased services from other providers
- Recreational and craft supplies used by clients

### *Line 27 – Client Total*

This line automatically sums the costs reported in Lines 20 through 26.

## INFORMATION TECHNOLOGY COSTS

### *Line 28 – Electronic Health Records*

The costs associated with the ongoing maintenance of the electronic health records (EHR) technology, as well as the related information technology support and non-capitalizable equipment, such as hardware, servers, scanners, signature pads, maintenance, and support fees, etc. Additionally, the costs associated with the ongoing upgrades or improvements of EHR technology, such as new modules, developer fees, etc. This does not include the cost associated with computers used by staff to access the EHR.

### *Line 29 –Software/Hardware*

The costs associated with software operating systems, applications, licenses, and cloud-based subscriptions, and the costs associated with routine purchases of computers, servers, networking equipment, and other physical information technology assets.

### *Line 30 – One-Time IT Investments*

The costs associated with one-time IT (information technology) purchases, such as data system migration costs, data center setup costs, software development and implementation, non-routine hardware purchases (non-capitalizable equipment), network infrastructure setup, etc. If cost is reported in this line, a brief description of the type(s) of costs is required on Schedule 1B, Section I.

### *Line 31 – Other Information Technology*

All other costs related to information technology functions not included in previous lines.

### *Line 32 – Information Technology Total*

This line automatically sums the costs reported in Lines 28 through 31.

## OCCUPANCY COSTS

### *Line 33 – Rent and Lease*

The costs associated with the rental or leasing of physical space, including buildings and offices. All rent and lease expense associated with related parties should be included here and on Schedule 1C, Less-Than-Arm's-Length (Related Party) Transactions; excess related party expense above cost will be automatically reclassified to Column 6, Unallowable, via Line 56 Excess Related Party Expense Above Actual Cost.

### *Line 34 – Depreciation and Amortization*

The costs associated with the depreciation or amortization of all depreciable assets owned by the company.

### *Line 35 – Interest - Building*

The costs of interest associated with the purchase, construction, or improvement of

buildings. Unallowable interest, if any, should be explicitly identified and reported as such in Column 6, Unallowable.

### *Line 36 – Utilities*

The costs associated with utilities at all facilities, such as electric, gas, water, trash, etc.

### *Line 37 – Facility and Grounds Maintenance*

The costs to maintain facilities and adjacent grounds, including janitorial costs and non-capitalized furniture and fixtures.

### *Line 38 – Property Insurance*

The costs to insure owned and leased facilities, assets, and physical property.

### *Line 39 – Other Occupancy*

All other costs associated with buildings and offices (owned, rented, leased, or donated), including real estate taxes.

### *Line 40 – Occupancy Total*

This line automatically sums the costs reported in Lines 33 through 39.

## OPERATING COSTS

### *Line 41 – Meetings and Events*

The costs associated with the provision or attendance of meetings, seminars, conferences, or other events. Also, the costs associated with internal or external staff development programs, such as training classes, including the cost of meeting space and equipment rental. This does not include travel-related costs, such as meals, hotel, etc., which are included in Line 42, Business Travel, Entertainment, Meals.

### *Line 42 – Business Travel, Entertainment, Meals*

The costs associated with business-related staff travel or entertainment expense, including meals, mileage allowances, hotel, and incidentals.

### *Line 43 – Legal Fees*

The costs paid for legal services, including retainers, for matters related to the company. Unallowable costs, if any, should be explicitly identified and reported as such in Column 6, Unallowable.

### *Line 44 – Lobbying*

The costs paid directly or indirectly for lobbying services. Unallowable costs should be explicitly identified and reported as such in Column 6, Unallowable.

### *Line 45 – Professional Membership Dues*

The costs paid to professional or other organizations for membership fees or dues. Unallowable costs, if any, should be explicitly identified and reported as such in Column 6, Unallowable.

### *Line 46 – Marketing, Public Relations, and Other Communications*

The costs associated with marketing, public relations, or other communication functions, including any form of communication to inform or offer services to the public or specific groups, such as web site fees, marketing and communication software, promotional items, etc. Unallowable costs, if any, should be explicitly identified and reported as such in Column 6, Unallowable.

### *Line 47 – Other Purchased Services and Professional Fees*

The costs associated with non-clinical professional practitioners and consultants who are not employees and are engaged for specified services on a fee or individual contract basis, such as auditors, linen service providers, etc.

### *Line 48 – Other Insurance*

The costs associated with all insurance other than health insurance, workers compensation, and property insurance. This includes (but is not limited to) professional liability, general liability, umbrella, fiduciary, directors and officers, cybersecurity, and auto.

### *Line 49 – Other Operating*

All other costs associated with operations, including (but not limited to):

- Bank and collection fees
- Licenses
- Equipment rentals and maintenance
- Interest (not related to building)
- Office supplies
- Postage, printing, copying
- Automobile expense for agency-owned or leased vehicles

### *Line 50 – Operating Total*

This line automatically sums the costs reported in Lines 41 through 49.

## OTHER UNALLOWABLE EXPENSE

### *Line 51 – Interest*

All interest expense not associated with the purchase, construction, or improvement of a building. All costs should be reported in Column 6, Unallowable.

### *Line 52 – Donated Supplies, Services, Space – Given to Others*

The value of donations given to other organizations, such as cash, services, supplies, space, etc. All costs should be reported in Column 6, Unallowable.

### *Line 53 – In-Kind Services and Donations Received*

The value of donations received by the company, and of in-kind services provided or supplies received, such as volunteer services or donated medication. All costs should be reported in Column 6, Unallowable.

### *Line 54 – Other Unallowable*

The costs explicitly identified as unallowable in Chapter 2 Standard 5, which have not been included in any previous line. All costs should be reported in Column 6, Unallowable. It is acceptable for unallowable costs to be reported in Column 6 of any previous line if those unallowable costs are comingled in accounts or cost centers which also contain allowable expense. This line is intended to capture unallowable costs that are distinctly identified within the general ledger accounts and are not comingled with allowable expense.

### *Line 55 – Other Unallowable Total*

This line automatically sums the costs reported in Lines 51 through 54.

## EXCESS RELATED PARTY EXPENSE

### *Line 56 – Excess Related Party Expense Above Actual Cost*

This automatically pulls the total by column from the calculation on Schedule 1C, Less-Than-Arm's-Length (Related Party) Transactions, and reclassifies amounts for Columns 2 through 5 into Column 6, Unallowable. No data input is necessary here.

### *Line 57 – Total Excess Expense Above Actual Cost*

This automatically pulls the amount reported in the previous line.

## TOTAL DIRECT COSTS

### *Line 58 – Total Direct Costs*

This automatically calculates the total direct costs for each column, including all costs reported in previous lines.

## INDIRECT COST ALLOCATION

### *Line 59 – Indirect Cost Allocation*

The total amount of indirect cost reported in Column 2, Line 58, should be allocated to the functional cost centers and/or programs and unallowable cost center in order to obtain full functional program cost.

Column 2 in this line automatically calculates as a negative of the total indirect costs in the previous line. No data input is necessary here.

The allocation of indirect cost amongst the remaining columns must be made using a reasonable statistic and based on sound methodologies. Indirect costs must be allocated to all columns containing direct expense, including Column 6, Unallowable.

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 sum to $0 to ensure the total amount of indirect costs are dispersed.

Documentation to substantiate the allocation methodology is required and should be summarized via narrative(s) on Schedule 1B, Indirect Cost Allocation Methodology.

### TOTAL COST

#### *Line 60 – Total Cost*

This line automatically calculates the total functional program cost in each column by adding Line 58, Total Direct Costs, and Line 59, Indirect Cost Allocation.

### CLIENT COUNTS

#### *Line 61 – Unduplicated Client Count*

This line includes the total number of unique clients served by the programs reported in Column 3, Encounter-Based Services with RVU Weights and All Integration Services.

#### *Line 62 – Cost per Unduplicated Client Count*

This is an automatic calculation equal to Total Cost reported in Column 3 Line 60 divided by Unduplicated Client Count reported in Column 3 Line 61.

### AUDITED FINANCIAL STATEMENT RECONCILIATION

#### *Line 63 – Total Expense per Audited Financial Statements*

The total expense per the audited financial statements should be entered here.

#### *Line 64 – Variance*

Total Cost reported in Column 7 Line 60 should reconcile to the total expenses shown on the Statement of Operations in the organization’s audited financial statements, including all auditor adjustments.

### *Line 65 – Indirect Cost Rate as a Percent of Direct Cost*

This automatically calculates an indirect cost rate by taking total Indirect costs reported in Column 2 Line 58 divided by the sum of remaining direct costs reported on Line 58 in Columns 3 through 6.

### *Line 66 – Indirect Cost Rate as a Percent of Total Cost*

This automatically calculates an indirect cost rate by taking total Indirect costs reported in Column 2 Line 58 divided by total costs reported on Line 58 in Column 7.

## Schedule 1A: Non-Clinical Direct Salary Limit

This schedule identifies the five largest non-clinical direct salaries paid during the cost reporting period, regardless of the non-clinical direct salary limitation. Direct salary includes wages and bonus amounts. This schedule must be used to document and calculate the excess non-clinical direct salaries paid during the cost reporting period; it is not appropriate to remove the excess amounts through mechanisms outside of Schedule 1A or off the cost report.

### *Column 1 – Job Title*

This column identifies the job title of the employee.

### *Column 2 – Schedule 1 Column*

This column identifies the column on Schedule 1 wherein the employee's wages are reported.

### *Column 3 – Number of Months in Role During Reporting Period*

This column identifies the number of months during the reporting period that the identified individual served in the non-clinical role. This column is informational in nature and does not impact the calculation of unallowable excess.

### *Column 4 – Total Salary and Bonus During Period*

This column identifies the total salary and bonus for the employee during the cost reporting period, including both clinical and non-clinical salary and bonus.

### *Column 5 – Percentage of Non-Clinical Time Spent*

This column identifies the percentage of non-clinical time spent during the cost reporting period. For individuals who served all their time in the non-clinical role during the entire reporting period, the percentage would be 100%; for individuals who served half their time in the non-clinical role during the entire reporting period, the percentage would be 50%.

### *Column 6 – Non-Clinical Salary and Bonus During Period*

This column automatically calculates the non-clinical salary and bonus for the employee during

the cost reporting period based on the total salary and bonus reported in Column 4 and the percentage of non-clinical time spent reported in Column 5.

#### *Column 7 – Unallowable Excess Non-Clinical Salary Above Limit*

This column automatically calculates the amount of direct salary reported in Column 6 in excess of the limit established for the reporting period. The total excess is summed by Schedule 1 reporting location and automatically reclassified as unallowable expense on Schedule 1.

## Schedule 1B: Indirect Cost Allocation Methodology

### Section I

This yes/no question asks for confirmation if one-time IT investments are reported in Line 30 on Schedule 1. If yes, the costs must be described on the schedule.

### Section II

This section of the schedule details the methods used to allocate indirect costs amongst all functional cost centers on Schedule 1. The preparer should break down the allocation methodology into the individual steps performed, in order, and provide enough detail for readers to understand the types of indirect costs included in each step of the allocation, the basis used to distribute costs in each step of the allocation, and any exceptions or nuances applicable.

The preparer should also verify if the indirect cost methodology described is the same that was used in the prior cost report period. If no, the reason for the change in methods between years should be explained.

## Schedule 1C: Less-Than-Arm's-Length (Related Party) Transactions

This schedule identifies all expenses paid to related party entities. For purposes of cost reporting, "related party" refers to an organization that possesses common ownership or control of the reporting entity. Multiple types of expenses paid to the same related entity can be combined into a single line on this schedule as long as the expenses are reported in the same column on Schedule 1.

If there are no related party transactions in the cost reporting period, select 'None' from the drop down. If there are related party transactions in the cost reporting period, the transactions must be reported on the schedule.

#### *Column 1 – Nature of Related Party Expense*

This column includes a general description of the type of expense included in the related party transaction.

### *Column 2 – Provider: Related Party Expense Recorded*

This column identifies the amount of related party expense recorded within the financial statements of the provider.

### *Column 3 – Related Party: Actual Cost Incurred*

This column identifies the cost actually incurred by the related entity to provide the service or supply to the provider. If possible, this amount should be exact. However, if exact expense incurred cannot be determined, it is acceptable for an estimate to be used based on the profit margin established by the financial statements of the related entity. In this case, the profit margin should be applied to the expense recorded by the provider in order to estimate the actual cost incurred by the related entity.

### *Column 4 – Unallowable Excess Provider Expense Above Related Party Actual Cost*

This column automatically calculates the difference between Column 2 and Column 3. No data input is necessary here.

### *Column 5 – Schedule 1 Column*

This column identifies the column on Schedule 1 wherein the related party transaction is reported.

### *Column 6 – Account Number(s) and/or Program(s)*

This column identifies the account numbers, programs, teams, departments, etc., wherein the related party transaction is recorded within the provider's financial statements.

### *Column 7 – Related Vendor, Individual, or Organization*

This column identifies the name of the related party.

## Schedule 2: Service Groups

This schedule accumulates amounts from the subsequent series of schedules, in order to summarize costs by applicable service group. No data entry is required on this schedule.

#### Columns

### *Column 1 – Service*

This column identifies the name of the service group for which cost data is accumulated.

### *Column 2 – Supplemental Schedule*

This column identifies the supplemental schedule from which cost data is pulled.

### *Column 3 – Direct Encounterable Costs*

This column identifies the total amount of direct cost associated with encounters provided for the service group.

### *Column 4 – Indirect Encounterable Costs*

This column identifies the total amount of indirect cost associated with encounters provided for the service group.

### *Column 5 – Direct Non-Encounterable Costs*

This column identifies the remaining direct cost, not associated with encounters provided, for the service group.

### *Column 6 – Indirect Non-Encounterable Costs*

This column identifies the remaining indirect cost, not associated with encounters provided, for the service group.

### *Column 7 – Subtotal Cost*

This column sums the previous four columns, to calculate the total cost associated with the service group.

#### Lines

### *Line 1 – Emergency Services*

This line identifies the costs associated with emergency services provided.

### *Line 2 – Consultative and Educational Services*

This line identifies the costs associated with consultative and educational services provided.

### *Line 3 – Outpatient Services*

This line identifies the costs associated with outpatient services provided.

### *Line 4 – Partial Hospitalization*

This line identifies the costs associated with partial hospitalization services provided.

### *Line 5 – Emergency and Crisis Behavioral Health Services*

This line identifies the costs associated with emergency and crisis behavioral health services provided.

### *Line 6 – Mental Health and Substance Use Outpatient Services*

This line identifies the costs associated with mental health and substance use outpatient services provided.

### *Line 7 – Behavioral Health High-Intensity Outpatient Services*

This line identifies the costs associated with behavioral health high-intensity outpatient services provided.

### *Line 8 – Care Management*
This line identifies the costs associated with care management services provided.

### *Line 9 – Outreach, Education, and Engagement Services*
This line identifies the costs associated with outreach, education, and engagement services provided.

### *Line 10 – Mental Health and Substance Use Recovery Supports*
This line identifies the costs associated with mental health and substance use recovery supports services provided.

### *Line 11 – Care Coordination*
This line identifies the costs associated with care coordination services provided.

### *Line 12 – Outpatient Competency Restoration*
This line identifies the costs associated with outpatient competency restoration services provided.

### *Line 13 – Screening, Assessment, and Diagnosis, Including Risk Assessment, Crisis Planning, and Monitoring to Key Health Indicator*
This line identifies the costs associated with screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicator services provided.

### *Line 14 – Subtotal*
This line sums the direct and indirect costs in order to calculate total encounterable costs and total non-encounterable costs for the service groups. These totals are reconciled to Schedule 1 Column 3 (for encounterable costs) and Schedule 1 Column 5 (for non-encounterable costs) to ensure all costs are included in the supplemental schedules.

### *Line 15 – Inpatient and Residential Services*
This line identifies the costs associated with inpatient and residential services provided. The total is reconciled to Schedule 1 Column 4 to ensure all costs are included in the supplemental schedule.

## Schedule 2A: Emergency Services
This schedule identifies costs associated with emergency services provided. These services are those that are necessary to stabilize individuals experiencing a behavioral health emergency. These include but are not limited to:

- Co-Responder Program
- Phone, tele-video and face-to-face emergency response
- Rapid Community Response

- Suicide prevention services
- 24/7 crisis response
- 24/7 urgent care response

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical.

#### Section I

This yes/no question asks for confirmation on if emergency services were provided during the reporting period. If yes, Section II must be completed. If no, Section II will be left blank.

#### Section II - Columns

##### *Column 1 – Program/Grant/Team*

This column identifies the name of the program, or grant, or team, or department, etc. (generically referred to as "program" within this section) for which costs are reported in subsequent columns. If the name of the program does not describe the type of services provided, add brief description to detail such (e.g. Sunshine Program – Outpatient Therapy).

##### *Column 2 – Encounterable Direct Cost*

This column identifies the amount of direct cost associated with encounters provided by the program. These are the costs that are reported in Column 3 on Schedule 1.

##### *Column 3 – Encounterable Indirect Cost*

This column estimates the amount of indirect cost associated with encounters provided by each program via an automatic calculation of direct program cost reported in Column 2 multiplied by the Indirect Cost Ratio calculated on Line 65 on Schedule 1.

##### *Column 4 – Total Cost*

This column automatically sums the direct and indirect costs reported in the previous two columns, in order to calculate the total costs associated with encounter-based services provided by the program.

##### *Column 5 – Non-Encounterable Direct Cost*

This column identifies the remaining direct cost, not associated with encounters provided by the program. These are the costs that are reported in Column 5 on Schedule 1.

##### *Column 6 – Non-Encounterable Indirect Cost*

This column estimates the remaining amount of indirect cost associated with each program via an automatic calculation of direct program cost reported in Column 5 multiplied by the Indirect Cost Ratio calculated on Line 65 of Schedule 1.

### *Column 7 – Total Cost*

This column automatically sums the direct and indirect costs reported in the previous two columns, in order to calculate the total costs associated with non-encounter-based services provided by the program.

### *Column 8 – FTEs*

This column identifies the FTEs associated with the program.

### *Column 9 – Clients*

This column identifies the number of clients associated with the program.

#### Section II - Lines

### *Lines 1-58*

These lines identify expense by individual program. Programs can be comingled if services provided are the same; for example, the expense for two residential homes can be comingled if the services provided at each home are consistent. When comingled, the names of each program should be included in Column 1 for identification purposes. However, programs providing different services should be reported individually.

### *Line 59*

This line automatically calculates the total expense reported in each column.

### *Line 60 – Total Emergency Services*

This line automatically sums encounterable and non-encounterable expense in Line 59 to calculate the total emergency services expense.

## Schedule 2B: Consultative and Educational Services

This schedule identifies costs associated with consultative and educational services provided. These services include all non-clinical services that enhance care coordination and the health and well-being of individuals. They include but are not limited to:

- Benefits coordination and acquisition
- Screening and assessment
- Referrals to other community-based services
- Education to build the capacity of other providers
- Consultation to physicians, emergency departments, and community centered boards
- Client transportation and medication delivery
- Community crisis debriefing services
- Daylight Partnership
- Law enforcement engagement and training

- Multidisciplinary case review for complex clients
- Navigation services
- Non-treatment school-based services including School-Based Mental Health Specialists
- Post-suicide education and consultation
- Prevention programs
- Senior reach programs
- Suicide prevention, awareness, training and response
- Wellness programs and health coaching

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if consultative and educational services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2C: Outpatient Services

This schedule identifies costs associated with outpatient services provided. These types of services focus on maintaining and improving functional abilities for a patient at risk of, or with a history of, psychiatric hospitalization. They include but are not limited to:

- Individual, group or family therapy
- Psychiatric rehabilitation
- Supporting housing/employment
- Programming for special populations
- Division of Vocational Rehabilitation (DVR) and extended services (DVRE)
- Individualized Placement and Support (IPS)
- Offender Behavioral Health Services (BHAS)
- Outpatient children's mental health programming
- Outpatient services for uninsured or underinsured populations
- Psychiatric medications, administration, and prescriber time

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if outpatient services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2D: Partial Hospitalization

This schedule identifies costs associated with partial hospitalization services. These services refer to medically-supervised, less-than-24-hour care, provided in a structured daily program with a minimum amount of weekly clinical contact hours, and are intended to serve individuals with high behavioral health needs with intensive services that cannot be sufficiently addressed with standard levels of outpatient services. They include but are not limited to:

- Transitional care following an inpatient stay
- Coordination of outpatient certifications
- Step-down services
- Intensive treatment services
- Assertive Community Treatment (ACT) or ACT-light services
- Rehabilitation
- Housing services and supports
- Wrap around services
- Hospital alternative services
- Urgent psychiatric evaluation or stabilization
- Community Dual Disorders Treatment Teams (CDDT)
- Court ordered evaluations
- Day treatment
- Homeless prevention services
- Intensive Outpatient (IOP)
- Supportive treatment services
- Ascent (First Episode Psychosis [FEP])
- High fidelity wraparound service
- Systems of Care involved Youth
- Trauma Systems Therapy Services

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if partial hospitalization services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2E: Emergency and Crisis Behavioral Health Services

This schedule identifies costs associated with emergency and crisis behavioral health services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if emergency and crisis behavioral health services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2F: Mental Health and Substance Use Outpatient Services

This schedule identifies costs associated with mental health and substance use outpatient services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if mental health and substance use outpatient services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2G: Behavioral Health High-Intensity Outpatient Services

This schedule identifies costs associated with behavioral health high-intensity outpatient services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if behavioral health high-intensity outpatient services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2H: Care Management

This schedule identifies costs associated with care management services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if care management services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2I: Outreach, Education, and Engagement Services

This schedule identifies costs associated with outreach, education, and engagement services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if outreach, education, and engagement services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2J: Mental Health and Substance Use Recovery Supports

This schedule identifies costs associated with mental health and substance use recovery supports services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if mental health and substance use recovery supports services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2K: Care Coordination

This schedule identifies costs associated with care coordination services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if care coordination services are provided and the answer to the question in Section 1 is "yes."

## Schedule 2L: Outpatient Competency Restoration

This schedule identifies costs associated with outpatient competency restoration services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if outpatient competency restoration services are

provided and the answer to the question in Section 1 is "yes."

## Schedule 2M: Screening, Assessment, and Diagnosis, Including Risk Assessment, Crisis Planning, and Monitoring to Key Health Indicator

This schedule identifies costs associated with screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicator services and is to be completed only by *new* comprehensive safety net providers.

The costs are broken down by program (or team, grant, department, etc.) to provide additional granularity. Different programs, teams, grants, or departments should not be summed together on one line unless the services provided by each are identical. This schedule should be completed in accordance with the instruction for Schedule 2A if screening, assessment, and diagnosis, including risk assessment, crisis planning, and monitoring to key health indicator services are provided and the answer to the question in Section 1 is "yes."

## Schedule 3: Per Diem Inpatient and Residential Services

This identifies costs associated with residential and inpatient facilities reported in Schedule 1 Column 4, Per Diem Inpatient Services and Residential Services without RVU Weights. These types of services are typically defined as treatment requiring an overnight stay at a facility, including:

- Acute Treatment Units (ATUs)
- Crisis Stabilization Units (CSUs)
- Residential facilities
- Residential Child Care Facilities
- Other forms of community settings

The costs are broken down by facility and program type to provide additional granularity. Facilities that serve multiple types of programs, services, or endorsements should be separated by such into individual lines. For example, if Facility A houses the ATU and CSU programs, then Facility A should be reported twice on Schedule 3, and the census days and costs for each program should be discreetly identified and separated between lines accordingly. The provider should list as many residential/inpatient facilities as it operates.

#### Columns

### *Column 1 – Name of Facility*

List the names of all the residential/inpatient facilities. List one facility per line and be as specific as possible.

### *Column 2 – Type of Facility, Endorsement, or Service*

Select the type of facility, endorsement, or service provided from the following list:

- Apartments
- Acute Treatment Unit (ATU)
- Crisis Stabilization Unit (CSU)
- Withdrawal Management Inpatient Hospital
- Residential

### *Column 3 – License Type*

Select the license under which each facility is registered (or select apartments for apartments) from the following list:

- Assisted Living Residence (ALR)
- Apartments
- Behavioral Health Entity (BHE)
- Controlled Substance License (CSL)
- Psychiatric Residential Treatment Facility (PRTF)
- Residential Child Care Facility (RCCF)
- Recovery Support Services Organization (RSSO)
- Therapeutic Residential Child Care Facility (TRCCF)

### *Column 4 – Bed Capacity*

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

### *Column 5 – Facility Open Date*

Identify the date on which the facility opened (or endorsement or service began) if the date occurred during the reporting period.

### *Column 6 – Facility Close Date*

Identify the date on which the facility closed (or endorsement or service concluded) if the date occurred during the reporting period.

### *Column 7 – Days Open During Period*

This column automatically calculates the number of days during the period that the facility was open (or the endorsement or service was active).

### *Column 8 – Procedure Code*

Select the procedure codes (and ASAM if applicable) related to the census days reported in Column 9. If multiple procedure codes (or ASAMs) are applicable to a single facility (or endorsement or service), then multiple lines should be used. Applicable procedure codes and

ASAMs are listed below:

- H0010 3.2 WM
- H0011 3.7 WM
- H0017
- H0018
- H0019+HB
- H0019+U1H0019+U2
- H0019+U3
- H2036 3.1
- H2036 3.3
- H2036 3.5
- H2036 3.7
- T2031
- N/A - Apartments

### *Column 9 – Census Days*

List the total number of census days for each facility by distinct procedure code and ASAM level. Leave blank those procedure code and ASAM level combinations that are not applicable to a particular facility. Census days for each procedure code are automatically summed in order to calculate per diems in subsequent columns.

### *Column 10 – Utilization Rate*

This column automatically calculates the utilization rate by dividing the census days by the days open during the period for each facility. No data entry is required in this column.

### *Column 11 – Total Expenses*

The total expenses per residential/inpatient facility should be entered in this column. The total expenses in this column should agree to the total of Schedule 1, Column 4. Guidance in Chapter 3 Schedule 1 for Column 4 should also be followed for this column.

### *Column 12 – Cost per Day - Total*

The total expenses from Column 11 divided by Column 9 Total Census Days.

### *Column 13 – Room and Board*

Room and board expenses per residential facility (inpatient facilities are excluded) should be entered in this column. 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 14 – Cost Per Day – Room & Board*

The total expenses from Column 13 divided by Column 9 Census Days.

### *Column 15 – Total Expenses less Room and Board*

The total expenses from Column 11 less the total expenses from Column 13.

### *Column 16 – Cost Per Day – Services*

The total expenses from Column 15 divided by Column 9 Census Days.

#### Lines

### *Lines 1 through 30 – All Residential and Inpatient Facilities*

These lines identify expense by individual facility, endorsement, or service for all residential and inpatient facilities.

### *Sub-lines a through c*

These lines identify the procedure codes and ASAM levels applicable to the residential and inpatient services provided at each facility. Census days for each procedure code and ASAM combination should be uniquely identified in the appropriate line.

### *Line 31 – Total All Facilities*

This line automatically sums the amounts for all facilities.

### *Line 32*

This line automatically pulls the direct inpatient and residential services expense reported in Schedule 1 Column 4.

### *Line 33*

This line automatically pulls the indirect costs allocated to inpatient and residential services on Schedule 1 Column 4.

### *Line 34*

This line automatically sums Lines 32 and 33.

### *Line 35*

This line automatically calculates the variance between Line 34 and Line 31. The variance should be $0 to ensure all residential and inpatient hospital expenses have been included on this schedule.

### *Line 36*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0010 3.2 WM. It then compares the Schedule 3 amount to that reported on Schedule 4 and calculates a variance.

### *Line 37*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0011 3.7 WM. It then compares the Schedule 3 amount to that reported on Schedule 4 and calculates a variance.

### *Line 38*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0017. It then compares the Schedule 3 amount to that reported on Schedule 4 and calculates a variance.

### *Line 39*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0018. It then compares the Schedule 3 amount to that reported on Schedule 4 and calculates a variance.

### *Line 40*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0019+HB.

### *Line 41*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0019+U1.

### *Line 42*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0019+U2.

### *Line 43*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H0019+U3. It then pulls the total amount reported on Schedule 4 for procedure code H0019 and automatically calculates the variance to the sum of lines 40-43.

### *Line 44*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H2036 3.1.

### *Line 45*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H2036 3.3.

### *Line 46*

This line automatically sums the census days reported on Schedule 3 that are associated with

procedure code H2036 3.5.

*Line 47*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code H2036 3.7. It then pulls the total amount reported on Schedule 4 for procedure code H2036 and automatically calculates the variance to the sum of lines 44-47.

*Line 48*

This line automatically sums the census days reported on Schedule 3 that are associated with procedure code T2031.

## Schedule 4: Base Unit Cost and PPS Rate Calculation

This schedule calculates the provider-specific base unit cost (BUC) and prospective payment system (PPS) rate.

### Lines 1 through 4: Base Unit Cost Calculation

The BUC is calculated as follows:

$$\text{BUC} = \frac{\begin{array}{c}\text{Total Costs from Column 3 on Schedule 1} \\ \text{– Non-RVU Integration Services Revenue} \\ \text{= Total allowable costs}\end{array}}{\text{Total RVUs}}$$

Total Cost: At the top of Schedule 4, the total cost is pulled in from Schedule 1 Column 3.

Non-RVU Integration Services Revenue: Payments from all payer sources for primary care services provided by integrated clinics owned by the provider, the cost of which are included on Schedule 1, Column 3, are to be reported as a third party liability offset on this schedule.

The Base Unit Cost is automatically calculated by dividing the total allowable cost for encounter-based services by the total RVUs.

### Lines 1 through 4: PPS Rate Calculation

The PPS rate is calculated as follows:

$$\text{PPS Rate} = \frac{\begin{array}{c}\text{Total Costs from Column 3 on Schedule 1} \\ \text{– Encounter-Based Essential Services Expense} \\ \text{= total allowable costs}\end{array}}{\text{Total PPS Encounters}}$$

Total Cost: At the top of Schedule 4, the total cost is pulled in from Schedule 1 Column 3.

Encounter-based Essential services expense (defined below) is *removed* from total costs on Schedule 1 Column 3.

Encounter-based Essential services expense: Expenses for providing encounter-based Essential services expense (i.e., non-PPS costs included in Column 3 on Schedule 1) are to be reported on this schedule. Refer to the State Behavioral Health Services Billing Manual for the types of services included in the Essential services definition. Computation of the encounter-based Essential services expense should include all associated personnel costs, building costs (such as utilities, rent and lease costs), medical supplies, software costs (such as EHR and network), and other indirect costs associated with providing the services. The allocation of associated costs must be based on reasonable statistics. Documentation to support the allocation basis must be maintained and made available upon request.

The total allowable costs for PPS rate is automatically calculated by removing the encounter-based Essential services expense from total costs on Schedule 1 Column 3.

Total PPS Encounters: At the top of Schedule 4, total PPS encounters are to be reported on this schedule. Refer to the State Behavioral Health Services Billing Manual for the list of services included in alignment with the reporting period.

The PPS Rate is automatically calculated by dividing the total allowable cost for PPS rate by the total PPS encounters.

### Lines 5 through 189: Non-Facility and Facility RVUs Calculation

This section is only required for provider with BHA contracts requiring a base unit cost calculation, primarily former Community Mental Health Centers. Comprehensive providers that do not have these contracts with BHA should not complete this section of Schedule 4.

Schedule 4 collects utilization data for encounter-based services with RVU weights and the costs of encounter-based donated services with RVU weights. All services provided outside of the locations owned or leased by the provider should be considered ‘non-facility’ place of service and use non-facility RVU weights. All services provided in a location owned or leased by the provider should be considered ‘facility’ place of service and use facility RVU weights.

In order to complete this schedule, 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 this schedule. The following instructions describe how utilization data is organized.

### *Column 1 – Non-Facility 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. 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 – Non-Facility RVU Weight*

This column contains the non-facility weights applicable to each CPT/HCPCS code listed. No data input is required here.

### *Column 3 – Non-Facility RVUs*

This column automatically calculates the non-facility RVUs by multiplying the units in Column 1 by the weight in Column 2. No data input is required here.

### *Column 4 – Cost per Non-Facility Unit of Service*

This column 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 5 – Facility 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.

### *Column 6 – Facility RVU Weight*

This column contains the facility weights applicable to each CPT/HCPCS code listed. No data input is required here.

### *Column 7 – Facility RVUs*

This column automatically calculates the facility RVUs by multiplying the units in Column 5 by the weight in Column 6. No data input is required here.

### *Column 8 – Cost per Facility Unit of Service*

This column 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.

## Schedule 5: Revenues

This schedule contains all revenues incurred during the cost report period.

#### CLIENT SERVICE REVENUE

This section contains the revenues associated with providing client services.

### *Line 1 – Medicaid – Regional Accountable Entities*

Revenues received directly from all Regional Accountable Entities for services to Medicaid members. These revenues may be paid on a fee-for-service basis, sub-capitation, or any other payment methodology.

### *Line 2 – Medicaid Fee for Service*

Revenues billed directly to HCPF on a fee-for-service basis for services and medications.

### *Line 3 – Medicare*

Revenues billed directly to Medicare for services and medications. This does not include Medicare Advantage plans.

### *Line 4 – Commercial Insurance*

Revenues billed to commercial insurance payers for services and medications. This includes Medicare Advantage plans.

### *Line 5 – Client Fees*

Revenues billed directly to clients. This includes self-pay, sliding scale, and copays for services and medications.

### *Line 6 – Non-Governmental Grants and Contracts*

Revenues received from all grants and contracts excluding grant and contract revenue included in Government Revenue below.

### *Line 7 – Other*

All other client service revenues received other than those included above or in Government Revenue.

### *Line 8 – Client Service Total*

No entry is required. Sum of lines 1 through 7.

## GOVERNMENT REVENUE

This section contains the revenues received from government sources.

### *Line 9 – Federal Grants and Contracts*

Revenues received from grants and contracts held directly with federal agencies.

### *Line 10 – Behavioral Health Administration - Direct*

Revenues received from contracts held directly with the Behavioral Health Administration (BHA).

### *Line 11 – Behavioral Health Administration - Indirect*

Revenues received from contracts with Administrative Service Organizations (ASO), Managed Service Organizations (MSO), and other organizations administering BHA funds.

### *Line 12 – Local Grants and Contracts*

Revenue received from grants and contracts with city, county, and other local governmental entities.

### *Line 13 – Other Government Grants and Contracts*

Revenues received from other governmental entities not included above.

### *Line 14 – Government Total*

No entry is required. Sum of lines 9 through 13.

## PUBLIC SUPPORT REVENUE

This section contains the revenues received from public support.

### *Line 15 – Donated Services*

The value of services donated to the provider.

### *Line 16 – Donated Hospital*

The value of hospital services donated to the provider.

### *Line 17 – Donated Medications*

The value of medications donated to the provider.

### *Line 18 – Donated Building Space*

The value of building space donated to the provider.

### *Line 19 – Other Donations Received*

The value of cash and other goods and services donated to the provider.

### *Line 20 – Public Support Total*

No entry is required. Sum of lines 15 through 19.

## OTHER INCOME REVENUE

This section contains the revenues received from other sources.

### *Line 21 – Interest*

Interest, dividends, and increases in the value of investments.

### *Line 22 – Management Fees*

Fees received from the provision of management services exclusive of the provision of services included above.

### *Line 23 – Other*

Revenues received from any other source not included above.

If Line 23, Other revenue is over 3% of Line 25, Total Revenue reported on Schedule 5, the other revenue source(s) must be detailed and reported in Line 23a, Line 23b, and Line 23c. Reconciliation is required between Line 23 and Line 23a, Line 23b, Line 23c.

If Line 23, Other revenue is under 3% of Line 25, Total Revenue reported on Schedule 5, further detail on Schedule 5 is not necessary.

### *Line 24 – Other Income Total*

No entry is required. Sum of lines 21 through 23.

## TOTAL REVENUE

### *Line 25 – Total Revenue*

This line automatically calculates the total revenue by adding Line 8, Client Service Total, Line 14, Government Total, Line 20, Public Support Total, and Line 24, Other Income

Total.

## AUDITED FINANCIAL STATEMENT RECONCILIATION

### *Line 26 – Total Revenue per Audited Financial Statements*

The total revenue per the audited financial statements should be entered here.

### *Line 27 – Variance*

Total revenue reported in Column 1 Line 25 should reconcile to the total revenues shown on the Statement of Operations in the organization's audited financial statements, including all auditor adjustments.

# Exhibit A: Colorado Comprehensive Provider Cost Report Template

https://hcpf.colorado.gov/behavioral-health-rate-reform

# Exhibit B: Items to be Submitted with Colorado Comprehensive Provider Cost Report by November 30

The following items must be submitted along with the Colorado Comprehensive Provider Cost Report by November 30. The supporting documentation, including the cost report preparation tool, must be free from significant errors and must maintain financial and statistical records in a manner consistent from one reporting period to another (whenever possible) in order to provide the required cost data and not impair comparability.

1. Annual audited financial statements for the cost report period.
2. Cost Report Review Questionnaire.
3. Working trial balance detailing account balances by program (team) for the cost report period.
4. 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).
5. 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.
6. 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.
7. 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.
8. Summary of encounters to substantiate amounts reported on Schedule 4 of the cost report.
9. Summary of units by procedure code to substantiate amounts reported on Schedule 4 of the cost report.

10. Summary of census days by program to substantiate amounts reported on Schedule 3 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 4, if any.
12. Documentation to support encounter-based Essential services expense, to substantiate amounts reported on Schedule 4, if any.

# Exhibit C: Glossary 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.

**Comprehensive Safety Net Provider** - A licensed behavioral health entity or behavioral health provider approved by the BHA to provide care coordination and the all of the following behavioral health safety net services, either directly or through formal agreements with behavioral health providers in the community or region: Emergency and Crisis Behavioral Health Services; Mental Health and Substance Use Outpatient Services; Behavioral Health High-Intensity Outpatient Services; Care Management; Outreach, Education, and Engagement Services; Mental Health and Substance Use Recovery Supports; Outpatient Competency Restoration; Screening, Assessment, and Diagnosis, Including Risk Assessment, Crisis Planning, and Monitoring to Key Health Indicator.

**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.

**Essential Safety Net Provider** - A licensed behavioral health entity or behavioral health provider approved by the BHA to provide care coordination and at least one of the following services: Emergency or crisis behavioral health services; Behavioral health outpatient services; Behavioral health high-intensity outpatient services; Behavioral health residential services; Withdrawal management services; Behavioral health inpatient services; Integrated care services; Hospital alternatives; Additional services that the BHA determines are necessary in a region or throughout the state.

**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.

**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.

**Prospective Payment System (PPS)** – Payment model that pays providers a standard rate for any qualifying encounter with a patient, regardless of what or how many specific services were rendered.

**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.