CABINET FOR HEALTH AND FAMILY SERVICES

COMMUNITY MENTAL HEALTH CENTER

REIMBURSEMENT MANUAL

PART I

GENERAL POLICIES AND GUIDELINES

Cabinet for Health and Family Services

275 East Main Street

Frankfort, Kentucky 40621

GENERAL POLICIES AND GUIDELINES

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SECTION 100 - INTRODUCTION

100. INTRODUCTION:

Comprehensive behavioral health services shall be reimbursed by the Cabinet for Health and Family Services (also referred to in this manual as the Cabinet or CHFS) for covered services through community mental health centers or boards as defined under Kentucky licensure regulations which are referred to in this manual as “providers.”

The General Policies and Guidelines and Principles of Reimbursement set forth in this manual specify the conditions, requirements, limitations and method of reimbursement for community mental health center services.

The Principles of Reimbursement which follow include provisions which specify the allowable costs to be recognized in determining reimbursement for covered services rendered to program eligible individuals. These principles are supplemented by Title XVIII (Medicare) Principles of Reimbursement with regard to limitations on costs for those areas or issues which are not specifically set forth in this manual.

For the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) and the Department for Community Based Services (DCBS), these principles are further supplemented by the Cabinet's contract(s) with each center. All requests to amend this manual shall be communicated, in writing, to the Benefit Policy Branch Manager, Division of Policy and Operations, The Department for Medicaid Services.

This manual may be reviewed Monday through Friday between the hours of 8 a.m. and 4:30 p.m., Eastern time, in the Office of the Commissioner, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky. Copies may be obtained from that office upon payment of an appropriate fee which shall not exceed appropriate cost. Additionally, the manuals listed above

have been made available on the Cabinet for Health and Family Services website, at http://www.chfs.ky.gov/dms/incorporated.htm.

SECTION 101 – SCOPE OF SERVICES

101. SCOPE OF SERVICES:

The Community Mental Health licensure regulations provide the basis for designation as a community mental health center. The Community Mental Health service and reimbursement regulations provide certain limitations with respect to services reimbursable by Title XIX (Medicaid).

Certain limitations with respect to services reimbursable by the DBHDID are delineated in manuals incorporated by reference within 908 KAR 2:060 and DBHDID contracts with providers.

102. REQUIREMENTS AND LIMITATIONS OF PARTICIPATION:

To participate as a reimbursable behavioral health provider under Cabinet Programs, each community mental health center shall be licensed by the appropriate state agencies.

When a provider elects to participate in the Title XIX Program, the allowable cost of all services provided in accordance with the requirements contained within 907 KAR 1: 044, 907 KAR 1:045, and 907 KAR 1:047 shall be included as a reimbursable cost of the participating provider and reimbursed up to the maximum established by DMS. All services covered under reimbursement provisions pursuant to 907 KAR 1:045 shall be cost settled through the community mental health center payment mechanism.

Having met licensure requirements, a provider may enter into a contract with the DBHDID for the provision of various services and will be issued a copy of the contract.

The contract may be nullified by DBHDID with appropriate prior notice if at any time the provider fails to meet a condition of licensure.

SECTION 103 - BILLABLE UNITS OF SERVICE

103. BILLABLE UNITS OF SERVICE:

The Cabinet's methods of reimbursement utilize billable units of service, payment rates and annual cost reports. Units of Service are defined in accordance with 907 KAR 1:045, Section 10. All timed units of service should be rolled up into one service line on the cost report. For DMS cost-settled services, CPT codes and the appropriate units for each CPT code should be used in accordance with 907 KAR 1:045. For DBHDID purposes, appropriate "T-codes" for targeted case management shall be used. Please refer to Appendix E-Service Codes document at http://dbhdid.ky.gov/CMHC/documents/guides/current/AppendixE.pdf.

SECTION 104 - DEPARTMENT FOR MEDICAID SERVICES (DMS)

TITLE XIX BEHAVIORAL HEALTH RATE SETTING

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104. DEPARTMENT FOR MEDICAID SERVICES (DMS) TITLE XIX BEHAVIORAL HEALTH RATE SETTING:

(A) DEPARTMENT FOR MEDICAID SERVICES (DMS) - RATE SETTING FOR STATE FISCAL YEARS ENDING ON OR BEFORE JUNE 30, 2018:

For the rate periods spanning November 1, 2016 to June 30, 2018, the Department for Medicaid Services will continue to reimburse providers based on existing fee schedules in the interim. Upon receipt and review of each individual facility's final cost report for this period cost settlements will be determined to reconcile interim reimbursement to total allowable reimbursement based on actual cost of providing behavioral health and primary care services.

(B) RATE SETTING FOR PERIODS AFTER JUNE 30, 2018:

Interim prospective payment reimbursement rates for behavioral health services shall be established annually for each facility on the basis of actual reasonable allowable cost from the facility's cost report of the fiscal year two years prior to the fiscal year for which an interim reimbursement rate is being established. Upon receipt and review of each individual facility's final cost report annually, cost settlements will be determined to reconcile interim reimbursement to total allowable reimbursement based on actual cost of providing behavioral and primary care services.

SECTION 105 - DEPARTMENT FOR MEDICAID SERVICES (DMS)

PRIMARY CARE SERVICE REIMBURSEMENT

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105. DEPARTMENT FOR MEDICAID SERVICES (DMS) - PRIMARY CARE SERVICE REIMBURSEMENT FOR PERIODS AFTER NOVEMBER 1, 2016:

In the interim, primary care services shall be reimbursed based on the Kentucky-specific Medicare physician fee schedule. Primary care services will be included in the final cost settlement calculated by the Department, based on the facility's reviewed reasonable and allowable cost of providing Medicaid services for a full fiscal year.

SECTION 106 - DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES (DBHDID) - METHOD OF REIMBURSEMENT

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106. DEPARTMENT FOR BEHAVIORAL HEALTH, DEVELOPMENTAL AND INTELLECTUAL DISABILITIES (DBHDID) - METHODS OF REIMBURSEMENT:

(1) Principles:

Providers of service may be paid on a fee for service basis, an expense reimbursement basis or a performance basis.

Fee for service basis means a provider is paid a fixed rate per unit of service.

Expense reimbursement basis means a provider is paid an amount equal to the expenses incurred by the provider in accordance with an approved Request for Funding.

Performance basis means a provider is paid for acceptable performance in relation to project objectives delineated in the provider's approved Request for Funding.

The particular method used, and the amount of reimbursement for any service shall be governed by the terms of a contract then in effect between the DBHDID and the provider.

(2) Amount of Payment:

DBHDID shall reimburse providers for each service category based on rates, and units of services reported if the fee for service method is being used, properly completed financial and program status reports if the expense reimbursement or performance methods are being used, allocations in accordance with the provider's approved request for funding, and any contract then in effect between the DBHDID and the provider.

107. UTILIZATION REVIEW:

If deemed necessary to assure appropriate utilization, systems of utilization review for determining norms and upper limitations and acceptable deviations from standards may be established. If established, these standards shall be used to identify possible abuse of the payment system and to prospectively inform providers of the promulgation of the limitations.

CABINET FOR HEALTH AND FAMILY SERVICES

COMMUNITY MENTAL HEALTH CENTER

REIMBURSEMENT MANUAL

PART II

PRINCIPLES OF REIMBURSEMENT

Cabinet for Health and Family Services

275 East Main Street

Frankfort, Kentucky 40621

PRINCIPLES OF REIMBURSEMENT

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SECTION 200 - INTRODUCTION

200. INTRODUCTION:

(A) Providers shall be reimbursed by the Cabinet for providing covered services to eligible clients.

(B) The principles of reimbursement which follow establish the guidelines and procedures which shall be used in determining reasonable allowable cost.

(C) These principles of reimbursement shall be applied by the Cabinet in the payment of claims.

(D) The Cabinet may furnish technical assistance to providers in the development of accounting and cost finding procedures which shall assure them equitable payment under all programs.

SECTION 201 - COST REIMBURSEMENT - GENERAL

201. COST REIMBURSEMENT - GENERAL:

(A) All expenses of a provider in the production of services shall be necessary and proper to be considered reasonable and allowable. The share of the total provider cost that is borne by one funding source shall be related to the services furnished its beneficiaries so that no part of their cost would need to be borne by any other funding source.

(B) These principles give recognition to such factors as depreciation, interest, certain educational costs, bad debts and cost to related organizations. With respect to allowable costs, some items of inclusion and exclusion are:

(1) Depreciation shall be an allowable cost unless the cost of the asset has been treated as an operating expense in accordance with Section 206 (A) (4) of this manual. A historical cost basis shall be used. Only assets actually in use for production of services for program beneficiaries shall be recognized. The latest version of the American Hospital Association Guidelines for estimating useful lives of depreciable assets shall be followed. (See: Section 206)

(2) Interest costs shall be allowable costs, with certain restrictions. (See: Section 207)

(3) Bad debts, charity, and courtesy allowances shall not be allowable costs. (See: Section 208)

(4) The costs associated with political contributions shall not be allowable costs.

(5) The costs associated with legal fees for unsuccessful lawsuits against the Cabinet shall not be allowable costs. Legal fees relating to lawsuits against the Cabinet shall only be included as allowable costs in the period in which the suit is settled after a final decision is rendered and the lawsuit is successful in favor of the provider, or

when otherwise agreed to by the parties involved, or ordered by a court of competent jurisdiction.

(6) With the exception of costs associated with item (5) of this section, the cost associated with any legal expense incurred in the normal and routine administration of the program shall be an allowable cost; however, the cost of legal fees incurred for judgments granted as a result of unlawful pursuits shall not be allowable.

(7) The value of services provided by non-paid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, shall not be an allowable cost.

(8) Costs (excluding transportation costs) for licensed training or educational purposes outside the Commonwealth of Kentucky are allowable costs. Even though such meetings per se are not educational, costs (excluding transportation) shall be allowable if educational or training components are included. Travel or related costs or expenses associated with non-licensed staff attending a convention, meeting, assembly, or conference shall not be allowable costs.

(9) Costs relating to Lobbying shall be unallowable costs.

(10) Costs related to outreach services shall be unallowable costs.

(11) Costs of patient transportation shall not be allowable.

(12) Costs incurred for research purposes shall not be allowable costs. (See: Section 210)

(13) Grants, gifts, and income from endowments shall not be deducted from allowable costs unless they are designated by the donor for the payment of specific costs. (See: Section 211)

(14) Discounts and allowances received on the purchase of goods or services shall be

reductions of the cost to which they relate. (See: Section 212)

(15) The costs of all motor vehicles used by management personnel shall be allowed up to twenty-five thousand dollars ($25,000) total valuation per vehicle. In the case of a purchased vehicle, the purchase price will be considered during review of compliance with the policy. In the case of a leased vehicle, the retail value of the vehicle will be considered during review of compliance with the policy.

(16) Program income, as defined by 45 CFR Part 74 shall be deducted from total allowable costs unless alternative cost reporting treatment shall have been approved, in writing, by the Cabinet.

(17) Costs for travel and associated expenses which are related to services provided under contracts with DBHDID shall be allowable, if they comply with the travel policies and procedures referred to in the specific contract(s).

(18) Costs associated with services provided in leased or donated space outside the walls of the facility shall be allowable.

202. APPORTIONMENT OF ALLOWABLE COSTS:

(A) Reimbursement under Cabinet programs involves a determination of (1) each provider's allowable costs of providing services, and (2) the equitable allocation of these costs to be borne by the various funding sources. A provider's allowable costs shall be determined in accordance with the principles of reimbursement delineated herein relating to reasonable allowable costs. The share of a provider's allowable costs to be borne by the various funding sources shall be determined in accordance with the principles set forth in this section, relating to the standardized allocation of costs.

(B) Methods shall be adopted which result in a funding Source's share of a provider's total allowable costs being directly related to the benefits derived from each item of cost.

(C) Prescribed Cost Allocation Methods. Each provider shall directly identify (charge) expenses to cost centers whenever it is practical to do so. If it is not practical to directly identify expenses, the provider shall develop allocation methods which shall not conflict with the following prescribed allocation methods and which utilize auditable statistics that bear direct relationship to the expense which is being allocated. The following methods of cost allocation shall be utilized when deriving cost data for the purpose of filing the annual cost reports required in Section 203 of this Manual.

(1) Cost Centers - Each provider shall establish and maintain a cost accounting system which shall identify expenses by service or project and location.

(2) Personnel Costs (Excluding Fringe Benefits) shall be identified for each employee based on 100 percent time reporting methods to group and report expenses to each

cost category. Detailed documentation shall be available upon request. Estimates shall not qualify as support for charges to services or supportive activities.

(3) Fringe Benefits shall be directly assigned or allocated to service or support activities based on the allocated Personnel costs of the employees to which they relate. (This allocation may be performed by employee, by location or by region.)

(4) Facility Costs shall be accumulated for each location (building) and allocated based on the square footage utilized by service or support activities within each location. Where the same space may be used for multiple service or support activities, an allocation of the space shall be made based on time studies which identify the actual direct hours of use for each service or support activity.

(5) Clinical Support Costs shall be allocated at the lowest organizational level practical based on units of service, if comparable; otherwise, clinical support costs shall be allocated based on the accumulated cost of those services which have benefitted. Indirect region wide clinical support costs shall be identified on Schedule A of the Annual Cost Report and allocated to all cost centers on Schedule B, except those identified as not receiving administrative cost allocations per the cost report based on total accumulated cost or the federal indirect rate, in accordance with the cost report instructions. Clinical support costs are those costs incurred to support service activities as defined in Section 209 (A) (4), and include medical records. (see: Part III of this Manual).

(6) Administrative Costs shall be allocated at the lowest organizational level practical based on accumulated cost or the federal indirect rate. Region-wide administrative costs shall be identified on Schedule A of the Annual Cost Report and allocated to all cost centers on Schedule B, except those identified as not receiving

administrative cost allocations per the cost report based on total accumulated cost in accordance with the cost report instructions (see: Part III of this Manual).

(D) If, at any time prior to the start of the fourth quarter of any cost reporting period, a provider wishes to use a method of cost allocation which differs from the prescribed methods described in (C) above, they may do so only after receiving the prior written approval of the Cabinet. Requests for approval shall be sent to Benefit Policy Branch Manager, Division of Policy and Operations, The Department for Medicaid Services.

203. FINANCIAL DATA AND REPORTS:

(A) General. Providers shall maintain sufficient financial records and statistical data for proper determination of costs payable by various funding sources. The cost and statistical data available from the provider's records shall be utilized to arrive at an equitable and proper payment for services to beneficiaries of each funding source.

(B) Cost Reports. For cost reporting purposes, each provider of services shall submit to DMS periodic reports of its operations which cover a consecutive twelve (12) month period. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Cabinet.

(C) Due Dates for Cost Reports. Cost reports shall be due on or before the last day of the sixth month following the close of the state fiscal year covered by the report. Payments to the provider may be suspended or the provider's participation in the Medicaid program may be terminated in the event an acceptable cost report is not filed with the Cabinet.

(D) Recordkeeping Requirements for New Providers. A newly participating provider of services shall, upon request, make available to the Cabinet for examination its fiscal and other records for the purpose of determining the provider's ongoing recordkeeping capability and inform the Cabinet of the date its initial cost reporting period shall end. This examination is intended to assure that: (1) the provider has an adequate ongoing system for furnishing the records needed to provide accurate cost data and other information capable of verification by qualified auditors and adequate for cost reporting purposes; (2) the provider's financial statements shall be audited and reported upon by a certified public accountant; and (3) no financial arrangements exist that shall obstruct the intent of the

Cabinet to reimburse providers in accordance with guidelines contained herein. The data and information to be examined include cost, revenue, statistical, and other information pertinent to reimbursement.

(E) Fiscal Year. All providers shall utilize a June 30 fiscal year end for cost reporting purposes.

(F) Continuing Provider Recordkeeping Requirements. The provider shall furnish information to the Cabinet as may be necessary to assure proper payment by the Cabinet including the extent to which there is any common ownership or control between providers or other organizations.

(G) Time Record Requirements. Personnel costs, whether considered direct or indirect costs shall be based on payrolls documented and approved in accordance with sound management practices and standard cost accounting methods. Payrolls shall be supported by time and attendance records which identify 100 percent of each individual employee's time.

(H) Access to Provider Records. The provider shall permit the Cabinet to examine records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payments due. These records shall be kept by the provider for a period of not less than eight (8) years, or until audit resolution whichever is longer, and shall include: (1) matters of provider ownership, organization, and operation; (2) minutes of meetings of Board of Directors and committees; (3) fiscal, patient treatment and other records; (4) federal income tax returns; (5) matters relating to asset acquisition, lease, sale or other dispositions; (6) franchise or management arrangements including costs of parent or "home office" operations; (7) client service charge schedules; (8) all matters pertaining to cost of operation; (9) amounts of income received by source and purpose; and (10) the flow of funds and working capital.

(I) Maintenance of Records. A CMHC shall maintain and make available any records and data necessary to justify and document: (1) costs to the CMHC; (2) services provided by the CMHC; (3) The cost of injectable drugs provided, if any, by the CMHC; (4) Cost allocations utilized including overhead statistics and supportive documentation; (5) any amount reported on the cost report; and (6) chart of accounts.

(J) Suspension of Program Payments to a Provider. If the Cabinet determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost under the program, payments to the provider may be suspended until the Cabinet is assured that adequate records are maintained, or the Cabinet may elect to set in motion the provisions outlined in KRS 210.440 relating to the withdrawal of funds or board recognition. Before suspending payments to a provider, the Cabinet shall send written notice to the provider of its intent to suspend payments. Any overpayment which may have occurred after the close of the provider's reporting period, but prior to the setting of a new rate as a result of the provider’s failure to maintain adequate records, shall be recovered by the Cabinet. The notice shall explain the basis for the Cabinet’s determination with respect to the provider's records and shall identify the provider's recordkeeping deficiencies. The provider shall be given the opportunity to submit a statement (including any pertinent evidence) as to why the suspension may not be put into effect.

204. ADEQUATE COST DATA AND COST FINDING:

(A) Principle. Providers shall provide adequate cost data. This shall be based on their financial and statistical records which shall be capable of verification. The cost data shall be based on the prescribed methods of cost finding contained in Section 202 and, unless otherwise approved in writing by the Cabinet, on accounting methods which shall be in conformity with generally accepted accounting principles.

(B) Definitions.

(1) Cost Finding. Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. Cost finding is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) Accrual Basis of Accounting. Under the accrual basis of accounting, revenue shall be reported in the period when it is earned regardless of when it is collected, and expenses shall be reported in the period in which they are incurred regardless of when they are paid.

(3) Prior Approval. Prior approval means that a provider shall secure approval, in writing, of a methodology change prior to implementation. Verbal approval shall not be acceptable and shall not be considered as prior approval.

(C) Adequacy and Consistency. Adequate cost information shall be provided in sufficient detail in the provider's records to support payments made for services rendered to beneficiaries. In order to provide the required cost data and not impair comparability, financial and statistical records shall be maintained in a manner consistent from one period

to another; however, a proper regard for consistency shall not preclude a desirable change in accounting procedures if there is reason to effect the change.

205. PAYMENTS TO PROVIDERS: SPECIAL CIRCUMSTANCES

(A) Rate Determination for a New Service. Reimbursement regarding a projection of the cost of a new Medicaid-covered service or expansion shall be made on a prospective basis in that the costs of the new service or expansion shall be considered when actually incurred as an allowable cost. A CMHC may request an adjustment to an interim rate after reaching the mid-year point of the new service or expansion. An adjustment shall be based on actual costs incurred.

(B) Bankruptcy or Insolvency of Provider. If, on the basis of reliable evidence, the Cabinet has a valid basis for believing that, with respect to a provider, proceedings have been or shall shortly be instituted in a State or Federal court for purposes of determining whether a provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Cabinet, notwithstanding any other regulation or program instruction regarding the timing or manner of the adjustments, to a level necessary to insure that no overpayment to the provider shall be made.

(C) Reimbursement of Out-of-state Providers. Reimbursement to a participating out-of-state community mental health center shall be the lesser of the: (1) charges for the service; (2) facility's rate as set by the state Medicaid Program in the other state; or (3) the state-wide average of payments for in-state community mental health centers.

206. DEPRECIATION: ALLOWANCE FOR DEPRECIATION BASED ON ASSET COSTS:

(A) Principle. An appropriate allowance for depreciation on buildings and equipment shall be an allowable cost within the limitations specified below. The depreciation shall be:

(1) identifiable and recorded in the provider's accounting records;

(2) based on the historical cost of the asset or, in the case of donated assets, the fair market value when donated;

(3) prorated over the estimated useful life of the asset using the straight line method; and

(4) any acquisition or improvement of a depreciable asset of at least $5,000 with at least a two (2) year life shall be capitalized except assets which are authorized to be purchased with funds allocated by DBHDID for an expense reimbursement project pursuant to approval of the provider's Request for Funding. If an asset with a value less than $5,000.00 is authorized to be purchased with DBHDID funds allocated for an expense reimbursement project, the provider shall treat the entire cost of that asset as an operating expense for the fiscal year in which it was purchased and shall not include any depreciation expense for that asset on the cost report for the year it is purchased or in subsequent years. The provider shall maintain purchase records that clearly identify the expense reimbursement project to which the operating expense is charged, and inventory records that clearly distinguish those assets from assets for which depreciation expenses are claimed on the cost report. Repairs and maintenance to an asset shall be allowable costs in the current accounting period, except that any repair and maintenance of an asset for $5,000 or an aggregate of

that amount during the reporting year shall be capitalized over the remaining useful life of the asset.

(B) Definitions.

(1) Historical Costs. Historical cost is the cost incurred by the present owner in acquiring the asset. For depreciable assets acquired after June 1, 1978, the historical cost used as the basis for depreciation shall not exceed the lower of current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of the purchase or fair market value at time of acquisition.

(2) Fair market value is the price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition. Usually the fair market price is the price at which bona fide sales have been consummated for assets of like type, quality, and quantity in a particular market when acquired.

(3) Current Reproduction Costs. Current reproduction cost is the cost at current prices, in a particular locality or market area, of reproducing an item of property or a group of assets. Where depreciable assets are concerned, this means the reasonable cost to build, reproduce in kind, or in the case of equipment or similar assets, to purchase in the competitive market.

(C) Recording of Depreciation. Appropriate recording of depreciation shall encompass the identification of the depreciable assets in use, the asset's historical costs, the method of depreciation, estimated useful life, and the asset's accumulated depreciation. In selecting a proper useful life, the current edition of American Hospital Association’s “Estimated useful lives of Depreciable Hospital Assets” shall be used.

(D) Depreciation Methods. Proration of the cost of an asset over its useful life shall be allowed on the straight-line method.

(E) Gains and Losses on Disposal of Assets. Gains and losses realized from the disposal of depreciable assets while a provider is participating with the Cabinet, or within one (1) year of the time the provider terminates participation, shall be included in the determination of allowable cost. The extent to which gains and losses shall be included shall be calculated on the proration basis recognizing the amount of depreciation charged under Cabinet funding in relation to the amount of depreciation, if any, charged or assumed in the period prior to the provider's participation, and in the period after the provider's participation, when the sale takes place or within one (1)year after termination.

(F) Basis of Assets Donated to a Provider. If an asset is donated to a provider, the basis for depreciation of the asset shall be the fair market value of the asset when donated.

(G) Basis of Assets Used Under the Program and Donated to a Provider. If an asset that has been used or depreciated under the Program is donated to a provider, the basis of depreciation for the asset shall be the lesser of the fair market value or the net book value of the asset in the hands of the owner last participating in the Program. The net book value of the asset shall be defined as the depreciable basis used under the Program by the asset's last participating owner less the depreciation recognized under the Program.

(H) Amortization of Start-Up Costs. For new service providers or newly established satellite centers of participating providers, proration of start-up costs shall be over Sixty (60) months utilizing the straight-line method.

(I) Depreciation of Assets Financed with Federal or Public Funds.

(1) Principle. Depreciation shall be allowed on assets financed with Federal or public funds unless specifically prohibited by a funding source or unless the cost of the asset has been treated as an operating expense in accordance with Section 206 (A)(4) of this manual.

(2) Application. Like other assets (including other donated depreciable assets), assets financed with Federal or public funds shall become a part of the provider's plant and equipment to be used in rendering services. If an asset is used in the provision of services for recipients of the Cabinet, payment for depreciation of the asset shall be a cost of the production of those services and shall be considered as such unless specifically prohibited by a funding source. An incentive for funding of depreciation shall be provided in these principles by the provision that investment income on funded depreciation shall not be treated as a reduction of allowable interest expense under Section 207 (B)(2)c of this manual.

207. INTEREST EXPENSE[1]:

(A) Principle. Necessary and proper interest as defined on both current and capital indebtedness shall be an allowable cost.

(B) Definitions.

(1) Interest. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for such purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and equipment, and capital improvements. Generally, loans for capital purposes are long term loans.

(2) Necessary. Necessary requires that the interest shall:

a. Be incurred on a loan made to satisfy a financial need of the provider. Loans which result in excess funds or investments shall not be considered necessary.

b. Be incurred on a loan made for the following purposes:

1. Represent interest on long-term debt existing when the provider enters into participation with the Cabinet plus interest on new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of services. If the debt is subject to variable interest rates found in "balloon" type financing, renegotiated interest rates

[1] The language shown is based on previously published CFR language, and is being used to demonstrate the overall concepts of the CFR guidance. Please refer to https://www.ecfr.gov for the most up to date version of the CFR, which would be followed in accordance with DMS policy.

subject to tests of reasonableness shall be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one (1) year.

2. Other interest for working capital and operating needs that directly relate to providing patient care shall be an allowable cost with the following exception. Short-term interest expense on a principal amount in excess of payments made under the rate equivalent to two (2) months experience based on actual Cabinet funding receivables, shall be disallowed in determining cost. The form of indebtedness may include, but shall not be limited to, notes, advances and various types of receivable financing.

c. Be reduced by investment income except where the income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been separated, if necessary. This shall not mean that the funds shall be kept in separate bank accounts, although this may be found to be the easiest method. If investment income is derived from combined or pooled funds, only that portion of investment income resulting from the facility's assets after separation shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense.

For purposes of this section, monies received from federal or state funding sources shall not be considered gifts or grants. Funds shall be considered sufficiently separated when the following criteria are met:

1. The source of the gifts and grants shall be identified and documented.
2. The receipt and disbursement of these funds shall be recorded in separate general ledger accounts (distinguishable by sources of funds). The balance of these funds in the general ledger accounts shall (at all times) be reconcilable with the investment account balances.

(3) Proper. Proper requires that interest shall:

a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest shall be allowable if paid on loans from the facility's donor-restricted funds, the funded depreciation accounts, or facility's qualified pension fund.

(C) Borrower-Lender Relationship.

(1) To be allowable, interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership, or personal relationship to the borrower. Presence of any of these factors may affect the "bargaining" process that usually accompanies the making of a loan, and may thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms-length transactions with lending institutions. Interest paid by the facility to partners, stockholders, or related organizations of the facility shall not be allowable. If the owner uses their own funds in a business, the funds shall be treated as invested funds or capital, rather than borrowed funds.

(2) Exceptions to the general rule regarding interest on loans from controlled sources of funds shall be made in the following circumstances.

If the general fund of a provider “borrows” from a donor-restricted fund and pays interest to the restricted fund, this interest expense shall be an allowable cost. The same treatment shall be accorded interest paid by the general fund on money “borrowed” from the funded depreciation account of the provider or from the provider’s qualified pension fund.

(3) If funded depreciation is used for purposes other than improvements, replacement, or expansion of facilities or equipment related to patient care, allowable interest expense shall be reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund if the deposits are used for other than the purpose of which the fund was established.

(D) Loans Not Reasonably Related to Patient Care.

Loans made to finance that portion of the cost of acquisition of a facility that exceed historical cost as determined under Section 206(B) of this manual or the cost basis as determined under Section 206(G) of this manual shall not be considered to be for a purpose reasonably related to patient care.

208. BAD DEBTS, CHARITY AND COURTESY ALLOWANCES[2]:

(A) Principle. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.

(B) Definitions.

(1) Bad Debts. Bad debts are amounts considered to be uncollectible from accounts and notes receivable which were created or acquired in providing services.

(2) Charity Allowances. Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

(3) Courtesy Allowances. Courtesy allowances are reductions in charges to physicians, clergy, members of religious orders and others for services received from the provider as approved by the policies of the governing body of the provider. Employee fringe benefits, such as hospitalization and personnel health programs, are not considered to be courtesy allowances. For DBHDID Funding Only: Bad debts shall not be included in allowable cost; however, uncollectible third party receivables which have been offset on billings to DBHDID may be included in allowable cost. Uncollectible third party receivables may be included in allowable cost after a six (6) month period, with three (3) documented efforts made to collect. Documented efforts made to collect may include:

a. Copies of bills sent to the client;

[2]The language shown is based on previously published CFR language, and is being used to demonstrate the overall concepts of the CFR guidance. Please refer to https://www.ecfr.gov for the most up to date version of the CFR, which would be followed in accordance with DMS policy.

b. Documentation that payment has been discussed and effort has been made to collect;
c. Written documentation that hardship has been applied through a fiscal review.
d. Properly documented telephone conversations. Uncollectable third party receivables, which meet these requirements shall be summarized by service category and included on Schedule F-2 of the Annual Cost Report as an adjustment to affect DBHDID funding only.

209. INDIRECT ADMINISTRATIVE COSTS:

(A) Definitions.

The following definitions shall apply unless the specific context dictates otherwise.

(1) "Direct Costs" means those costs that can be identified specifically with and charged in whole or in part to a particular project, service, program or activity of an organization.

(2) "Indirect Costs" means those costs of an organization which are not specifically identified with a particular project, service, program, or activity but never-the-less are necessary to the general operation of the organization and the conduct of the activities it performs.

(3) "Administrative Activities" means those activities performed by an organization in the development and implementation of policy and the management of the organization necessary to fulfill the functions and obligations of the organization. These activities generally include, agency and personnel management, accounting, auditing, and legal services.

(4) "Service Activities" means those activities carried out by an organization which are integral and necessary to the production or delivery of specific products or services.

(5) "Indirect Administrative Costs" means those costs for administrative activities of an organization which are not specifically identifiable with a particular project, service, program or activity.

(6) Indirect region-wide administrative costs means those indirect administrative costs that are not properly allocable at a local level.

(7) “Cost Allocation Plan” means the written description of processes for identification, accumulation, and distribution of costs together with the allocation methods used.

(8) “Federal Indirect Rate” means the rate approved by the United States Department for Health and Human Services (HHS) for grantee institutions to be used to calculate indirect costs as a percentage of direct costs.

(B) Indirect Administrative Cost Limitation in Contracts.

(1) Indirect costs, which shall be calculated utilizing the approved federal indirect rate, if the provider has an approved federal indirect rate. A provider shall include in indirect costs on line one of the cost report the same category of costs identified as indirect within the approved federal indirect rate supporting documentation. Direct costs shall be those costs identified as direct within the approved federal indirect rate. The federal indirect rate shall be applied to the same category of expenses identified as direct during the federal rate determination; or if the provider does not have a federal indirect rate, those costs of an organization that are not specifically identified with a particular project, service, program, or activity but nevertheless are necessary to the general operation of the organization and the conduct of the activities it performs. The actual allowable cost of indirect services as reported on the cost report shall be allocated to direct cost centers based on accumulated cost if a federal indirect rate is not available.

(2) The Department for Behavioral Health, Developmental and Intellectual Disabilities shall limit payment to providers for indirect region-wide administrative cost to no more than ten (10) percent of any Provider Agreement or contract total. For the purpose of this provision, provider agreement and contract total means total actual, allowable expenses reimbursable by the Cabinet.

(3) If offering a contract for bid or negotiation, the Community Mental Health Center shall clearly indicate that it shall limit its reimbursement of indirect administrative cost to no more than ten (10) percent of the total actual allowable expenses. If total indirect administrative cost exceeds the limit, the additional expense shall be the responsibility of the contractor and not the Commonwealth.

(4) Indirect administrative costs paid for with contractor local funds and used to satisfy in-kind or matching requirements shall be limited to an allowable amount calculated using the provider's federal indirect rate.

(5) If more restrictive contract provisions or federal or state laws or regulations apply to a particular contract, the laws, regulations, or contract provisions shall prevail with respect to limitations of indirect administrative cost.

(6) If an audit results in a finding that the indirect administrative cost limitations have been exceeded for the period of performance under the contract, payment made by the Cabinet to the contractor in consideration of the cost shall be subject to recovery from the contractor by the Cabinet.

(C) Documentation Requirements for Costs.

(1) All direct or allocable direct charges shall be documented by appropriate source documents to support the direct charging of the expense.

(2) The contractor shall document the method used to allocate direct or indirect costs.

(3) Reports of audits performed to meet federal or state requirements and which shall be conducted by independent public auditors, Cabinet auditors, or the State Auditor, and shall contain a statement as to the compliance of the contractor with the cost limitations.

(4) Current federal indirect rates should be supported by the letter from the federal agency that communicated the rate. Additionally, documentation supporting the rate calculation should be submitted, such as an expense listing with mapping of direct versus indirect expense.

(D) Subcontracts. For DBHDID: If the primary contractor subcontracts with any non-state government agency or organization or individual pursuant to or relating to its contract or provider agreement with the Cabinet, the indirect administrative cost of the primary contractor shall not exceed ten (10) percent of the total actual allowable expenses reimbursed by the Cabinet. Indirect administrative fees paid to the subcontractor shall not exceed ten (10) percent of the total amount of the subcontract. The indirect administrative costs of the primary contractor including administrative fees paid to subcontractor(s) charged to the Cabinet shall not in the aggregate exceed ten (10) percent of the total actual allowable expenses reimbursed by the Cabinet.

SECTION 210 - RESEARCH COSTS

210. RESEARCH COSTS[3]:

(A) Principle. Costs incurred for research purposes, over and above usual patient care, shall not be includable as allowable costs.

(B) Exception. If research is conducted in conjunction with and as part of patient services, the costs of usual patient services shall be allowable to the extent that these costs are not met by funds provided for the research. Under this principle, studies, analyses, surveys, and related activities to serve the provider's administrative and program needs shall be included as allowable costs.

[3] The language shown is based on previously published CFR language, and is being used to demonstrate the overall concepts of the CFR guidance. Please refer to https://www.ecfr.gov for the most up to date version of the CFR, which would be followed in accordance with DMS policy.

SECTION 211 - GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

211. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS:

(A) Principle.

Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs. Unearned income shall not be deducted in the year that it is received and not earned, but shall be deducted in the year that it is earned.

(B) Definitions.

(1) Unrestricted Grants, Gifts, Income from Endowments. Unrestricted grants, gifts, and income from endowments are funds, cash or otherwise, given to a provider without restriction by the donor as to their use.

(2) Designated or Restricted Grants, Gifts and Income from Endowments. Designated or restricted grants, gifts and income from endowments are funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This shall not refer to unrestricted grants, gifts, or income from endowments which have been restricted for a specific purpose by the provider.

(C) Application.

(1) Unrestricted funds, cash or in kind contributions, shall be considered the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs.

(2) Donor-restricted funds which are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all patients who use the services covered by the donation.

(3) Justice Block Grant funds shall be treated as restricted funds and shall be deducted from operating costs in determining a provider's allowable cost.

(4) Unrestricted State General Funds in the form of allotments or grants received from the Cabinet for Health and Family Services and designated by the Cabinet as unrestricted shall not be deducted from operating costs in determining reimbursable cost.

212. PURCHASE DISCOUNTS AND ALLOWANCES, AND REFUNDS OF EXPENSE[4]:

(A) Principle. Discounts and allowances received on purchases of goods or services shall be reductions of the costs to which they relate. Similarly, refunds of previous expense payments shall be reductions of the related expense. Reductions to cost shall be made in the same year the discount, allowance or refund is received.

(B) Definitions.

(1) Discounts. Discounts, in general, are reductions granted for the settlement of debts.

(2) Allowances. Allowances are deductions granted for damage, delay, shortage, imperfection, or other causes, excluding discounts and returns.

(3) Refunds. Refunds are amounts paid back or credits allowed because of over collections.

[4] The language shown is based on previously published CFR language, and is being used to demonstrate the overall concepts of the CFR guidance. Please refer to https://www.ecfr.gov for the most up to date version of the CFR, which would be followed in accordance with DMS policy.

213. COST TO RELATED ORGANIZATIONS[5]:

(A) Principle. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control shall be included in the allowable cost of the provider at the cost to the related organization. However, the cost shall not exceed the price of comparable services, facilities, or supplies that may be purchased elsewhere by a prudent and cost-conscious buyer.

(B) Definitions.

(1) Related to Provider. Related to the provider means that the provider to a significant extent is associated or affiliated with, has control of, or is controlled by the organization furnish1ng the services, facilities, or supplies.

(2) Common ownership. A relationship shall be considered to exist when an individual or individuals possess five (5) percent or more of the ownership or equity in the facility and the facility and the institution or organization serving the provider.

(3) Control. Control shall exist when an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(C) Exception. An exception may be provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Cabinet: that the supplying organization is a bona fide separate organization; that fifty-one (51) percent or more of the supplier's business activity of the type carried on with the provider is transacted with persons

[5] The language shown is based on previously published CFR language, and is being used to demonstrate the overall concepts of the CFR guidance. Please refer to https://www.ecfr.gov for the most up to date version of the CFR, which would be followed in accordance with DMS policy.

and organizations other than the provider and its related organizations; that there is an open, competitive market for the type of services, facilities, or supplies furnished by the supplier; that the services, facilities, or supplies are those which commonly are obtained by organizations such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the providers; and that the charge to the provider is in line with the charge for these services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for these services, facilities, or supplies. In these cases, the charge by the supplier to the provider for these services, facilities, or supplies shall be allowable as cost.

KRS 210.110, as enacted, relating to conflicts of interest shall be applied.

SECTION 214 - REASONABLE COST OF PURCHASED SERVICES

214. REASONABLE COST OF PURCHASED SERVICES:

(A) Principle. The reasonable cost of purchased administrative services furnished under arrangements shall be an allowable cost, provided the services performed are necessary.

(B) Definitions.

(1) Reasonableness. Reasonableness shall require that the cost of the services:

a. be an amount that would ordinarily be paid for comparable services by comparable providers; and

b. be pertinent to the operation and sound conduct of the provider.

(2) Necessary. Necessary shall require that the function be pertinent to the operation and sound conduct of the provider.

(C) Application.

(1) The Cabinet may establish criteria for use in determining the reasonable allowable cost of purchased services furnished by individuals under arrangements with a provider.

(2) If services are performed under arrangements on a full-time or regular part-time basis, the reasonable cost of these services shall not exceed the amount that would ordinarily be paid for comparable services by comparable providers to full-time or regular part-time employees plus a travel allowance.

(3) If services are performed under arrangements on a limited part-time or intermittent basis (less than fifteen (15) hours per week), the reasonable allowable cost of these services shall be the usual and customary charge for the service prevailing in the area plus a travel allowance.

(4) Costs shall be evaluated so that the costs shall not exceed what prudent and cost-conscious management would pay for the given service.

SECTION 215 - COST RELATED TO SUB-CONTRACT OR AFFILIATE AGREEMENTS

215. COST RELATED TO SUB-CONTRACT OR AFFILIATE AGREEMENTS:

(A) Principle. Costs applicable to services provided by a sub-contractor or affiliate shall be included in the allowable cost of the purchasing center. However, the Medicaid Program policy shall be that the cost of the purchase of professional services shall be permitted only when the community mental health center maintains an oversight and supervisory relationship with the service contractor with regard to the services purchased. The contract shall provide that all Medicaid requirements applicable with regard to the provider apply to the subcontractor, that complete records relating to provision of services shall be maintained, and that access to the records by representatives of the Department for Medicaid Services and United States Department of Health and Human Services shall be made available. The cost of professional behavioral health services purchased by the center shall be recognized as an allowable cost only when the services are provided under a subcontract.

(B) Definitions.

(1) Sub-contract. Sub-contracts shall be used for all agreements involving Cabinet for Health and Family Services funds between the provider and other agencies. A sub-contract is an agreement between the provider and another service provider for the purchase of specific services at a specific dollar amount. The provider shall be responsible for the delivery of these services and for the expenditure of funds relating to these services by the Cabinet for Health and Family Services.

(2) Affiliate Agreement. Affiliate agreement, as herein defined, is a cooperative agreement between two agencies. In this arrangement the client becomes the

responsibility of the agency providing the service. There shall be no exchange of Cabinet for Health and Family Services funds.

(C) Application.

(1) Costs. When the provider purchases services, the reported cost on the cost report shall include the payments made by the provider for those services and not the sub-contractor's or affiliate's cost of providing those services.

(2) Units of Service. The units of service reported with the cost shall be the number of services billed to a payor by the provider. Any other services provided by the sub-contractor or affiliate shall not be included in the cost reporting mechanism.

(3) Allocation of Administrative and General (A&G). A portion of the provider's administrative and general cost shall be allocated to the sub-contractors and affiliates. Any provider that has a substantial amount of expenditures to sub-contractors or affiliates may document a procedure for allocating A & G that is fair and equitable to that provider. Methods that may be considered would be direct-charging of in-house costs to the affiliate or sub-contract cost centers, establishing a set indirect rate, or charging in-house expenses to the affiliate cost centers by using time surveys and other statistical data. Any method of allocation other than accumulated cost shall be presented to the Cabinet for prior approval. This request for prior approval shall be received before the start of the fourth quarter. Allocation and definition of administrative cost shall be in compliance with all applicable Cabinet policies or regulations governing administrative costs and charges.

(D) Contracts and Agreements. Contracts and agreements between the provider and the sub-contractor shall be in conformity with applicable Federal and State regulations. The guidelines listed below concern specific items which shall be in every contract and

agreement and shall:

(1) Include all terms of the contract in one (1) instrument, be dated, and be executed by authorized representatives of all parties to the contract;

(2) Have a definite effective and termination date for the provision of services;

(3) Contain a detailed description of the services to be provided and of the methods, including sub-contracting to be used by the provider in carrying out its obligations under the contract;

(4) If eligibility determinations are to be made by the sub-contractor, contain criteria which shall be used by the provider for these determinations and specify that the sub-contractor shall inform individuals of their right to fair hearings;

(5) Provide for a stated number of units of service at a specific dollar rate, or for a specific dollar amount, or for costs to be determined in accordance with acceptable cost allocation methods;

(6) Specify the method and source of payment to the sub-contractor, including collection and disposition of fees, if applicable;

(7) Include a statement that the sub-contractor shall meet applicable State or Federal regulations;

(8) Specify the locations of facilities to be used in providing services;

(9) Provide that sub-contracts written by the Provider shall contain the terms and conditions which are contained in the Provider's contract or agreement with the Cabinet that are designated as applicable to subcontractors;

(10) Specify requirements for fiscal and program responsibility, billing, records controls, report, audits, and monitoring procedures; and

(11) Provide for access by State and Federal officials to financial and other records pertaining to the program. These records shall be kept by subcontractors for a period of not less than eight (8) years or until audit resolution, whichever is later; and

(12) In the case of a private sub-contractor or medical or remedial care or health-related homemaker services, include a provision that the provider shall provide information about ownership or control, past business transactions, and certain other disclosing entities; and

(13) Specify no state or federal funds shall be used for any cost relating to Lobbying.

(E) Access to Records. The sub-contractor or affiliate shall permit the Cabinet or its representative to examine such records and documents as shall be necessary to ascertain information pertinent to the determination of the proper amount of program costs. See Section 203 of this manual for retention requirements.

SECTION 216 - DETERMINATION ALLOWABLE COST FOR DRUGS

216. DETERMINATION OF ALLOWABLE COST FOR DRUGS:

The cost of drugs shall be allowable only when the drugs are necessary for use by the provider staff.

(1) For DBHDID: the cost of drugs shall be an allowable cost when the drugs are necessary for the treatment of clients and the costs are sanctioned by DBHDID.

(2) For DMS: service or drug costs associated with the services or drugs, in accordance with 907 KAR 1:045.

217. COST RELATED TO PATIENT SERVICES[6]:

(A) Principle. All payments to providers of services shall be based on the reasonable allowable cost of covered services under the programs and related to the treatment of beneficiaries. Reasonable allowable cost shall include all necessary and proper costs incurred in rendering the services, subject to principles which relate to specific items of revenue and cost.

(B) Definitions.

(1) Reasonable Allowable Cost. Reasonable allowable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used and the items to be included. These principles consider both direct and indirect costs of providers of services. The costs with respect to individuals covered by a CHFS program shall not be borne by individuals not so covered, and the costs with respect to individuals not so covered shall not be borne by CHFS.

(2) Necessary and Proper Costs. Necessary and proper costs shall be costs which are appropriate in developing and maintaining the operation of patient treatment facilities and activities. They shall be costs which are common and accepted occurrences in the field of the provider's activity.

(C) Application. The determination of reasonable allowable cost of services shall be based on cost related to the treatment of beneficiaries under the program. Reasonable allowable

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costs, both direct and indirect, shall include all necessary and proper expenses incurred in rendering services, such as administrative costs, facility maintenance costs, and premium payments for employee health and pension plans. However, where the provider's operating cost include amounts not related to patient services, specifically not reimbursable under the program, or flowing from the provision of luxury items services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed services), the amounts shall not be allowable. The provider may require clarification of whether a particular cost item may be allowable and may request the advisement of the Cabinet. Upon receipt of all pertinent data regarding the item in question, the Cabinet shall take the matter under consideration and issue a response binding upon the provider and the Cabinet.

SECTION 218 - DETERMINATION OF COST OF SERVICES TO BENEFICIARIES

218. DETERMINATION OF COST OF SERVICES TO BENEFICIARIES:

(A) Principle. Total reasonable allowable cost of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program shall be based upon actual services received by program beneficiaries. The ratio of program covered units of service to total units of service shall be used to determine reimbursable program cost for those services by department or direct service cost center.

(B) Definitions.

(1) Apportionment. Apportionment shall mean an allocation or distribution of allowable cost between program beneficiaries and other patients.

(2) Cost. Cost refers to reasonable allowable cost as described in Section 217 of this manual.

(3) Average Departmental Cost per Unit of Service. Average Departmental cost per unit of service shall mean the amount computed for each specified department by dividing the total reasonable allowable cost for services rendered by the total number of covered units of service in the accounting period.

SECTION 219 - LIMITATIONS ON ALLOWABLE COSTS

219. LIMITATIONS ON ALLOWABLE COSTS:

(A) Principle. In the determination of the provider's reasonable allowable cost, costs determined to be in excess of those necessary in the efficient delivery of covered behavioral health or substance abuse services shall be excluded. These limitations may be made with respect to covered services direct or indirect total costs, costs of specific items or services, or groups of items or services. These limits shall be applied prospectively when practical.

(B) Application. In determining the limits to be applied, providers or their costs may be classified by factors considered appropriate and practical.

(C) Data. In establishing limits, determination of the costs necessary for efficient delivery of covered behavioral health or substance abuse services shall be based on cost report, utilization review data, or other data providing indicators of current reasonable costs.

(D) NOTICE OF LIMITS TO BE APPLIED. The following shall constitute notice of initial limitations to become effective with the implementation of the program.

(1) Reasonable Compensation. The cost of administrative staff salaries shall be limited to the average salary for the given position as established for the geographic area on www.salary.com, when available. The cost of practitioner salaries shall be limited to the median salary for the southern region as reported in the Medical Group Management Association (MGMA) Physician Compensation and Production Survey Report, if available.

(2) Limitations Defined in Other Sections of This Manual. In the determination of the provider's reasonable allowable costs the limitations defined in other sections of this manual shall be applicable.

220. REIMBURSEMENT FOR PROFESSIONAL SERVICES:

(A) Principle. When the professional practitioner is an employee of the provider either full-time or part-time, or if the professional services are provided under arrangements by persons on the staff of the provider, all reasonable allowable costs of providing those services to program beneficiaries shall be recognized as costs of the provider. For Title XIX: Services provided under the conditions stated above shall be billed by the provider and shall not be billed to the program directly by the professional practitioner. When professional services are provided under contractual or referral (linkage) arrangements by persons not on the staff of the provider, the costs of their services, including contractual amounts, shall not be reorganized as costs of the provider to be billed by the provider, but may be billed directly to the appropriate element of the Medicaid Program by the professional practitioner when applicable. All contractual arrangements shall be in written form and shall stipulate the nature and scope of services to be performed, the responsibilities of the parties and the nature and amount of all consideration.

(B) Definitions.

(1) On Staff. On staff means a professional who provides services to registered patients of record of the provider on behalf of the provider either at the provider's site, the patient's residence, or another location which is usually other than the private office of the professional. Service providers which operate under community mental health center licensure providing components of the required behavioral health or substance abuse services shall be considered on staff.

(2) Program Beneficiary. A program beneficiary means a program eligible beneficiary

who is a registered patient of record with the provider and who is under treatment by a professional on the staff of the provider.

(C) Application. If services are provided by professionals considered to be on the staff of the provider the reasonable allowable cost shall be included in the provider's cost. Professional services provided by professional considered on staff shall be reimbursed through the Community Mental Health Program. Title XIX Application: Professional services provided by professionals who are not considered to be on the staff of community mental health center shall not be included in the provider's cost, but covered services shall be reimbursed through the other provisions of the Medicaid Program.

(D) Reasonable Cost Determination. For the purposes of determining reasonable costs of professional services the following shall apply:

(1) With respect to full-time or regular part-time employees, the reasonable cost of these services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services by comparable providers and shall be determined in accordance with provisions of Section 219 of this manual. The cost of practitioner staff salaries shall be limited to the median salary for the southern region, for the given position as established by MGMA.

SECTION 221 - PROVIDER REIMBURSEMENT REVIEWS AND APPEALS

221. PROVIDER REIMBURSEMENT REVIEWS AND APPEALS:

(A) Title XIX Programs: Participating providers may appeal DMS's decisions relating to the application of the policies and procedures governing the Community Mental Health payment system in accordance with Title 907 KAR 1:671.

(B) DBHDID Programs:

(1) A participating provider may appeal any determination made by the department in the application of the provisions of this manual and any action that affects reimbursements that is based on the application of those provisions.

(2) A written notice of appeal shall be submitted to the Commissioner no later than thirty (30) days after a provider has been notified of a determination or an action affecting reimbursements. The notice of appeal shall:

a. specify the determination(s) or action(s) being appealed including, if applicable, each adjustment made to the provider's cost report or reimbursements based on a desk review or a cost report audit;

b. specify the reasons the provider believes the determination or action is unwarranted;

c. include any documentation the provider considers relevant to support the appeal; and

d. specify alternative determination(s) that should be made or action(s) that should be taken.

(3) The Commissioner shall cause the appeal to be reviewed and evaluated with consideration of the provisions of applicable laws and regulations.

(4) The Commissioner shall issue a written decision including findings of fact and conclusions on the appeal no later than thirty (30) days after receipt of a notice of appeal unless the Commissioner determines that a provider conference may result in a mutually satisfactory resolution of the appeal.

(5) If the Commissioner determines that a provider conference should be held the Commissioner or the Commissioner's designee shall schedule a provider conference to be held no later than thirty (30) days after receipt of a notice of appeal or at a later time agreeable to the Commissioner and the provider.

(6) If a provider conference is held it shall be conducted according to the following procedures:

a. The Commissioner or the Commissioner’s designee shall preside over a provider conference.

b. The procedure shall be recorded and a transcription made.

c. The provider or their authorized representative may present any oral arguments or documentation which they consider relevant to support the contention that the department should not take the appealed action or should rescind an action already taken.

d. Department staff who are knowledgeable of applicable laws and regulations shall explain the department's determinations and actions being appealed and may present any documentation which supports the department's action or which demonstrates if the department's determinations and actions are consistent with applicable laws and regulations.

e. If appealed determinations or actions are based upon reports provided by persons other than Department employees, those individuals may attend a

provider conference, explain the report(s) and the basis of those reports.

f. The Commissioner or the Commissioner's designee may question any of the participants and may permit any questions or discussion among participants if that will contribute to a just decision on the appeal consistent with applicable laws and regulations.

(7) If a provider conference is held the Commissioner shall issue a written decision on the appeal no later than thirty (30) days after the provider conference. The written decision shall include findings of fact and conclusions.

(8) If a provider disagrees with the Commissioner's decision on an appeal they shall have the right to an administrative hearing.

(9) The provider may appeal the decision (and underlying program issue) by submitting a request for an administrative hearing to the Commissioner within thirty (30) days after receipt of the decision.

(10) The Commissioner shall forward the request to the Cabinet for Health and Family Services, Division of Administrative Hearings, within five (5) working days of receipt.

(11) The scope of the administrative hearing shall be restricted to the issues raised pursuant to section 222 Subsection B(2) of this manual.

(12) The administrative hearing process shall be in accordance with KRS Chapter 13B.

CABINET FOR HEALTH AND FAMILY SERVICES

COMMUNITY MENTAL HEALTH CENTER

REIMBURSEMENT MANUAL

PART III

ANNUAL COST REPORT INSTRUCTIONS

Cabinet for Health and Family Services

275 East Main Street

Frankfort, Kentucky 40621

INTRODUCTION TO THE COMMUNITY MENTAL HEALTH CENTER COST REPORT:

The Annual Community Mental Health Center (CMHC) Cost Report provides for the submission of cost and statistical data which shall be used for cost settlements and to establish interim payment rates. All CMHC facilities participating in the Kentucky Medicaid Program shall utilize this cost report form and process. All required information is pertinent and shall be submitted as accurately and completely as possible.

The Kentucky Medicaid program shall require all CMHC providers to follow direct costing principles in preparation of annual cost reports. Direct costing means the process of directly attributing specific dollars incurred in operations to the CMHC, based upon the actual costs to each cost center. Thus, the cost reporting system requires accurately captured costs to be reflected individually for CMHC cost centers. It is the intent of the Medicaid Program that the costs reflected for the CMHC operations are as accurate as possible and not distorted via cost allocations. For direct and indirect personnel costs, 100% time reporting methods shall be utilized to group/report expenses to each cost category. Detailed documentation shall be available upon request.

Costs shall be reported as they appear in the provider's accounting records and books. Schedules A-1 and C of the cost report have been provided to make any necessary accounting adjustments or reclassifications to ensure proper cost finding.

Direct costing shall not be utilized on a selective basis in order to distort the cost finding process.

COVER PAGE SCHEDULE:

A. Enter the cost report period begin date and end date.

B. Enter the provider name for the CMHC.

C. Enter the provider number for the CMHC and any other licensed provider types.

D. Enter the address of the applicable board.

SCHEDULE A – UNIT COST INFORMATION:

A. Providers must create a crosswalk of trial balance expenses, indicating the cost report line and column of the cost report where each trial balance expense is reported. Additionally, if facility-specific unit codes are available, enter in column 2. Any entered unit codes will automatically update through all cost report schedules.

B. Review cost center descriptions in column 3. Standardized cost centers applicable to all CMHCs have been pre-populated in white. If your facility has additional custom cost centers, blank cells can be utilized, which will automatically update through all cost report schedules. All applicable non cost-settled and non-allowable cost centers must be added to the cost report to present total facility costs. This is necessary to ensure that administrative costs are appropriately allocated to all functional areas of the facility's operations.

C. Enter personnel costs (salary, fringe, and retirement contributions) in columns 4-6, respectively. For direct and indirect personnel costs, 100% time reporting methods shall be utilized to group/report expenses to each cost category. Detailed documentation shall be available upon request. Column 7 will automatically summarize columns 4-6 to display total personnel costs.

D. Facility costs (which include capital costs, depreciation, and property, plant, and equipment costs) should be entered in columns 8 and 9. If costs are directly assigned, enter the facility costs in column 8. If costs are allocated, enter the facility costs in column 9.

E. Travel and transportation costs should be entered in columns 10 and 11. If costs are directly assigned, enter the travel and transportation costs in column 10. If costs are allocated, enter the travel and transportation costs in column 11.

F. Enter costs for subcontracted services in column 12.

G. Enter all other operating costs in column 13.

H. The column 14 subtotal before adjustments equals the sum of columns 7 through 13.

I. Column 15 shows any adjustments to the cost report from Schedule C, column 12 of the cost report. Additions to cost are shown as positive numbers and subtractions are shown as negative numbers.

J. The column 16 subtotal after adjustments equals the sum of columns 14 and 15.

K. Column 17 is the total of all “local” reclassifications or allocations for each cost center which have been entered on Schedule A-1 of the cost report. Increases are shown as positive numbers (from Schedule A-1, column 11) and decreases are shown as negative numbers (from Schedule A-1, column 12).

L. Column 18 is total Schedule A cost and equals the sum of columns 16 and 17.

M. Note regarding outreach services: Outreach services should be either directly reported to Schedule A, line 36 or to a cost center falling under the “Non-Cost Settled Services” or “Non-Reimbursable Cost Centers” heading. If these services are provided in connection with a specific grant, it is expected that costs will be offset against grant revenue received. Some examples of outreach services include, but are not limited to, supporting Medicaid enrollment efforts, helping connect Medicaid recipients to care options, and service promotion through posters, fact sheets, or social media.

N. Note regarding indirect costs: Indirect costs shall be calculated utilizing the approved Federal indirect rate, if the provider has an approved federal indirect rate. Providers shall include in indirect

costs on line 1 of the cost report the same category of costs identified as indirect within the approved federal indirect rate supporting documentation. Similarly, direct costs shall be those costs identified as direct within the approved federal indirect rate. The Federal indirect rate will be applied to the same category of expenses identified as direct during the Federal rate determination. For providers that do not have a federal indirect rate, indirect costs are defined as those costs of an organization which are not specifically identified with a particular project, service, program, or activity but nevertheless are necessary to the general operation of the organization and the conduct of the activities it performs. The actual allowable cost of indirect services as reported on the cost report shall be allocated to direct cost centers based on accumulated cost if no Federal indirect rate is available.

Lines 2 through 6 may also be used for indirect cost reporting; however, all costs on these lines should be reclassified to either line 1 or lines 7 through 269 on Schedule A-1 for proper cost allocation.

SCHEDULE A-1 – LOCAL RECLASSIFICATIONS AND ALLOCATIONS:

Schedule A-1 is used for cost allocations/reclassifications between cost centers on a functional basis. If no functional basis exists, a pooled allocation of administrative cost based on accumulated cost will be performed on Schedule B.

A. Column 1 displays the line number of each adjustment.
B. Enter the adjustment number in column 2. Every line of an individual adjustment will need an adjustment number. For example, if $5,000 was being reclassified from Schedule A, line 8, with $2,500 each going to lines 10 and 11, three lines would show adjustment #1.
C. In column 3, the cost center description will be automatically populated based on the line number entered in column 5 (Step D below).

D. Enter the supporting work paper reference in column 4.

E. Enter each cost center line number (from Schedule A, column 1) involved in the allocation on a separate line in column 5. In the example in step A, there would be three cost centers utilized: 8, 10, and 11.

F. Column 6 will be automatically populated with Schedule A, column 17. All increases/decreases that occur on Schedule A-1 will be summarized on Schedule A, column 17.

G. In column 7, choose the appropriate allocation basis from the following options: Square Footage, Accumulated Cost, Direct Cost, Units of Service, Time Spent, Payroll Dollars, or Payroll Percentage. All allocation bases within one adjustment must be identical.

H. If accumulated cost is the chosen allocation basis in column 7, the form will populate the appropriate statistic in column 8 (from Schedule A, column 16, plus any previous A-1 allocations affecting the given cost center). If any other allocation basis is chosen in column 7, column 8 will say “INPUT”. The appropriate statistic must then be keyed in column 8 in place of the formula.

I. Column 9 will automatically sum the Column 8 statistic for all lines with the same Column 2 adjustment number and a Column 13 indicator of yes.

J. Column 10 will automatically divide the Column 8 cost center allocation statistic by the Column 9 total allocation statistic.

K. Column 11 will automatically apportion Column 12 amounts using the allocation percentages calculated in Column 10.

L. In column 12, input <u>as a negative number</u> the amount of cost to decrease for a given cost center(s). In the example above, -$5,000 would be keyed for the Schedule A, line 8 row.

M. In column 13, choose “Y” if costs <u>should</u> be allocated to the Schedule A line referenced in column 5. Choose “N” if costs should <u>not</u> be allocated to the Schedule A line referenced in column 5. In the example above, the adjustment to Schedule A, line 8 would be marked “N” and the adjustments

to Schedule A, lines 10 and 11 would be marked “Y”. After the completion of Step I, column 9 will automatically subtotal the allocation statistic from column 8 for every line of the adjustment where column 13 is marked “Y”. In column 10, a pro-rata share factor will be determined for each applicable line. In column 11, the increase to each line will be calculated.

N. After all lines of a given allocation have been entered, add an adjustment description to column 3 explaining the purpose of the reclassification or allocation. (Note: The formula in column 3 should be overwritten with the adjustment description.)

SCHEDULE B – ADMIN STEPDOWN:

A. In column 4, total costs from Schedule A, column 18 will be populated.

B. In column 5, cost for subcontracted services will be populated from Schedule A, column 12.

C. Column 6 will be calculated by subtracting column 5 subcontract cost from column 4 total costs. This step is performed to exclude subcontract cost from the allocation basis for administrative costs.

D. At the top of column 7, if the facility has a federally-approved indirect cost rate, key the approved rate in cell G9. The calculated administrative cost rate will populate in cell G10.

E. If a federal indirect rate has been keyed, column 7 admin costs will be determined by multiplying column 6 costs (net of subcontracts) times the federal indirect rate. If no federal indirect rate is keyed, column 7 admin costs will be determined by multiplying column 6 costs (net of subcontracts) times the calculated indirect rate.

F. Column 8 total allowable expenses equals the sum of column 5 subcontract cost, column 6 net costs, and column 7 administrative costs.

G. In column 9, choose “Y” if admin costs should be allocated to this cost center. Choose “N” if admin costs should not be allocated to this cost center. Additional supporting documentation will be required to justify the exclusion of admin costs for any line. For providers with an indirect rate, any

line not considered direct during the Federal indirect rate determination should be marked as "N" to ensure that no indirect cost is attributed to that line.

SCHEDULE B - ADMIN STEPDOWN (LIMITED):

No input is required on this schedule. The purpose of this schedule is to automatically pull values from the non-limited Schedule B and apply the DBHDID imposed 10% limit on admin costs. This will not affect the DMS cost settlement calculations but will be used by DBHDID for their purposes. Also see Schedule F-1, column 7.

SCHEDULE C – TOTAL NON-ALLOWABLE EXPENSES:

A. In columns 4-11, enter as a negative number non-allowable expenses related to out-of-state travel, bad debts, in-kind donations, interest expense offsets, management vehicle cost, program income, restricted donations, and other non-allowable items.
B. Column 12 summarizes all non-allowable amounts, which will populate Schedule A, column 15.

SCHEDULE D – TOTAL UNITS OF SERVICE:

A. Enter Medicaid units of service in columns 4 and 5. Use column 4 for traditional Medicaid (non-managed care) services. Use column 5 for Medicaid managed care services.
B. Units of service for services rendered to waiver recipients for the Supports for Community Living (SCL), Michelle P, SCL Consumer Directed Option (CDO), Michelle P CDO, Enhanced Transition (ET), and Acquired Brain Injury (ABI) waivers should be entered in columns 6-11, respectively.
C. Enter units of service related to the Department for Behavioral Health, Developmental and Intellectual Disabilities in column 12.
D. Enter all other units of service in column 13.
E. Total units of service will be summarized in column 14.

SCHEDULE E – TITLE XIX COST PER SERVICE:

A. Total XIX cost will be populated in column 4 (from columns 10 and 11 of Schedule E-1).

B. Total XIX units of service will be populated in column 5 (from columns 4 and 5 of Schedule D).

C. Average XIX cost per unit will be calculated by dividing column 4 XIX cost by column 5 XIX units.

SCHEDULE E-1 – TITLE XIX COST APPORTIONMENT:

A. Medicaid units of service will be populated in columns 4 and 5 (from Schedule D, columns 4 and 5).
B. Total units of service will be populated in column 6 (from Schedule D, column 14).
C. In columns 7 and 8, Medicaid utilization percentages will be determined. For example, column 4 non-MCO units will be divided by column 6 total units to determine the non-MCO utilization percentage.
D. Total allowable costs will be populated in column 9 (from Schedule B, column 8).
E. In columns 10 and 11, Medicaid cost will be apportioned. For example, the column 7 utilization percentage will be multiplied by the column 9 total cost to determine non-MCO cost in column 10.

SCHEDULE F – DBHDID COST PER SERVICE:

A. Total DBHDID cost will be populated in column 4 (from column 8 of Schedule F-1).
B. DBHDID adjustments to cost will be populated in column 5 (increases from Schedule F-2, column 6 and decreases from Schedule F-2, column 7).
C. Adjusted DBHDID cost will be calculated in column 6 (column 4 plus column 5).
D. Total DBHDID units of service will be populated in column 7 (from column 14 of Schedule D).
E. Average DBHDID cost per unit will be calculated in column 8 by dividing column 6 DBHDID cost by column 7 DBHDID units.

SCHEDULE F-1 – DBHDID COST APPORTIONMENT:

A. DBHDID units of service will be populated in column 4 (from Schedule D, column 14).
B. Total units of service will be populated in column 5 (from Schedule D, column 16).
C. In column 6, the DBHDID utilization percentage will be determined by dividing column 4 DBHDID units by column 5 total units.

D. Total DBHDID allowable costs will be populated in column 7 (from Schedule B (Limited), column 8).

E. In column 8, DBHDID cost will be apportioned by multiplying the column 6 utilization percentage by column 7 total allowable cost.

SCHEDULE F-2 – DBHDID ADJUSTMENTS:

A. In column 3, enter a brief explanation for the adjustment

B. If applicable, enter the supporting work paper reference in column 4. This column is not required.

C. In column 5, enter the line number for the cost center to which the adjustment applies.

D. In column 6, key as a positive value any increase in costs applicable to the adjustment. These amounts will automatically flow to Schedule F, column 5.

E. In column 7, key as a negative value any decrease in costs applicable to the adjustment. These amounts will automatically flow to Schedule F, column 5.

SCHEDULE G – GRANT IDENTIFICATION:

A. Enter the grant identification number in column 1.

B. In column 2, enter a description of the grant and related services.

C. Enter the source of the grant in column 3.

D. In column 4, enter the total dollar amount of the grant.

CABINET FOR HEALTH AND FAMILY SERVICES

COMMUNITY MENTAL HEALTH CENTER

REIMBURSEMENT MANUAL

PART IV

ANNUAL COST REPORT

Cabinet for Health and Family Services

275 East Main Street

Frankfort, Kentucky 40621

COMMUNITY MENTAL HEALTH CENTERS

ANNUAL COST REPORT
AUDITED

FOR PERIOD BEGINNING

AND PERIOD ENDING

PROVIDER NAME

PROVIDER NUMBERS

CMHC	-
SCL	-
TCM - ADULT	-
TCM - CHILD	-
IMPACT PLUS	-
IMPACT PLUS	-
OTHERS	-

ADDRESS OF THE BOARD

Provider Name 0

Schedule A

For the Period January 0, 1900 through January 0, 1900

Unit Cost Information

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Salary	(5) Fringe	(6) Retirement Contributions	(7) = (4)+(5)+(6) Total Personnel	(8) Facility Direct	(9) Facility Allocated	(10) Travel & Transportation Direct	(11) Travel & Transportation Allocated	(12) Sub-contracts	(13) Other Operating	(14) Subtotal Before Adjustments	(15) Adjustments Cost/Revenue (Sch C)	(16) Subtotal After Adjustments	(17) Reclass & Allocations Inc / (Dec) (Sch A-1)	(18) Total Cost	(19) Sch B
1		Region-Wide Indirect Administration				-							-	-	-	-	-	1
2		Local Clinical & Clerical Support				-							-	-	-	-	-	2
3		SCL Clinical & Clerical Support				-							-	-	-	-	-	3
4		Affiliate / Subcontract Support				-							-	-	-	-	-	4
5						-							-	-	-	-	-	5
6						-							-	-	-	-	-	6
7		DMS Cost Settled Services																7
8		Individual Therapy				-							-	-	-	-	-	8
9		Group Outpatient Therapy				-							-	-	-	-	-	9
10		Mobile Crisis Services				-							-	-	-	-	-	10
11		Therapeutic Rehabilitation Services				-							-	-	-	-	-	11
12		Psychological Testing				-							-	-	-	-	-	12
13		Partial Hospitalization				-							-	-	-	-	-	13
14		Screening, Brief Intervention, and Referral to Treatment				-							-	-	-	-	-	14
15		Assertive Community Treatment				-							-	-	-	-	-	15
16		Intensive Outpatient Program Services				-							-	-	-	-	-	16
17		Residential Services for Substance Use Disorders				-							-	-	-	-	-	17
18		Residential Crisis Stabilization Services				-							-	-	-	-	-	18
19		Day Treatment				-							-	-	-	-	-	19
20		Peer Support Services				-							-	-	-	-	-	20
21		Comprehensive Community Support Services				-							-	-	-	-	-	21
22		Pregnant Women - Substance Use Prevention				-							-	-	-	-	-	22
23		Psychiatry and Medication Management				-							-	-	-	-	-	23
24		Primary Care Services																24
25		Medical and Nursing Services				-							-	-	-	-	-	25
26		Laboratory				-							-	-	-	-	-	26
27		Radiology				-							-	-	-	-	-	27
28		Physical Therapy				-							-	-	-	-	-	28
29		Occupational Therapy				-							-	-	-	-	-	29
30		Speech-Language Pathology				-							-	-	-	-	-	30
31						-							-	-	-	-	-	31
32						-							-	-	-	-	-	32
33						-							-	-	-	-	-	33
34						-							-	-	-	-	-	34
35		Non-Cost Settled Services																35
36		Outreach Services				-							-	-	-	-	-	36
37		Targeted Case Management (Substance Use Disorder)				-							-	-	-	-	-	37
38		Targeted Case Management (Severe MI or Child SED)				-							-	-	-	-	-	38
39		Targeted Case Management (MH / SU Disorder and CPHI)				-							-	-	-	-	-	39
40		Community Residential (Daily) MH				-							-	-	-	-	-	40
41		Community Residential (Daily) IDD				-							-	-	-	-	-	41
42		Transitional Living (SA Preg Women)				-							-	-	-	-	-	42
43		Transitional Living (SA)				-							-	-	-	-	-	43
44		Adult Day Training On-Site				-							-	-	-	-	-	44
45		Adult Day Training Off-Site				-							-	-	-	-	-	45
46		Transitional Living (SA Family Program)				-							-	-	-	-	-	46
47		DUI Assessment				-							-	-	-	-	-	47
48		PASRR				-							-	-	-	-	-	48
49		Respite				-							-	-	-	-	-	49
50		Leisure Services				-							-	-	-	-	-	50
51		Supported Employment				-							-	-	-	-	-	51
52		Consultation & Education				-							-	-	-	-	-	52
53		DUI Education				-							-	-	-	-	-	53
54		Support Coordination (IDD)				-							-	-	-	-	-	54
55		Group Home				-							-	-	-	-	-	55
56		Specialized Services & Supplies				-							-	-	-	-	-	56
57		Adult Foster Care				-							-	-	-	-	-	57
58		Staffed Residence				-							-	-	-	-	-	58
59		Family Home Provider				-							-	-	-	-	-	59
60		Occupational Therapy				-							-	-	-	-	-	60
61		Physical Therapy				-							-	-	-	-	-	61
62		Speech Therapy				-							-	-	-	-	-	62
63		Behavior Support				-							-	-	-	-	-	63
64		Support Broker (CDO)				-							-	-	-	-	-	64
65		Community Day Supports (CDO)				-							-	-	-	-	-	65
66		Adult Day Training				-							-	-	-	-	-	66
67		Supported Employment				-							-	-	-	-	-	67
68		Home and Community Supports (CDO)				-							-	-	-	-	-	68
69		Personal Care				-							-	-	-	-	-	69
70		Companion Care				-							-	-	-	-	-	70
71		Community Living Supports				-							-	-	-	-	-	71

Schedule A-1
Local Reclassifications & Allocations

Provider Name 0
For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Adj #	(3) Cost Center / Explanation	(4) Work Paper Ref	(5) Schedule A Line	(6) Sch A Column	(7) Allocation Basis	(8) Cost Center Allocation Statistic	(9) Total Allocation Statistic	(10) Allocation Percentage	(11) Increase	(12) (Decrease)	(13) Include in Allocation (Y/N)
1												
2												
3												
4												
5												
6												
7												
8												
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10												
11												
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31												
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39												
40												
41												
42												

Provider Name 0
For the Period January 0, 1900 through January 0, 1900

Schedule B
Admin Stepdown

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Total Costs from Schedule A	(5) Subcontracts from Sch. A	(6) Net Costs	(7) Admin Allocation	(8) Total Allowable Expenses	(9) Include in Allocation
					Federal Indirect Rate	0.000000%		
					Calculated Rate	0.000000%		
1		Region-Wide Indirect Administration	-	-	-	-	-	
2		Local Clinical & Clerical Support						
3		SCL Clinical & Clerical Support						
4		Affiliate / Subcontract Support						
5								
6								
7		DMS Cost Settled Services						
8		Individual Therapy	-	-	-	-	-	Y
9		Group Outpatient Therapy	-	-	-	-	-	Y
10		Mobile Crisis Services	-	-	-	-	-	Y
11		Therapeutic Rehabilitation Services	-	-	-	-	-	Y
12		Psychological Testing	-	-	-	-	-	Y
13		Partial Hospitalization	-	-	-	-	-	Y
14		Screening, Brief Intervention, and Referral to Treatment	-	-	-	-	-	Y
15		Assertive Community Treatment	-	-	-	-	-	Y
16		Intensive Outpatient Program Services	-	-	-	-	-	Y
17		Residential Services for Substance Use Disorders	-	-	-	-	-	Y
18		Residential Crisis Stabilization Services	-	-	-	-	-	Y
19		Day Treatment	-	-	-	-	-	Y
20		Peer Support Services	-	-	-	-	-	Y
21		Comprehensive Community Support Services	-	-	-	-	-	Y
22		Pregnant Women - Substance Use Prevention	-	-	-	-	-	Y
23		Psychiatry and Medication Management	-	-	-	-	-	Y
24		Primary Care Services						
25		Medical and Nursing Services	-	-	-	-	-	Y
26		Laboratory	-	-	-	-	-	Y
27		Radiology	-	-	-	-	-	Y
28		Physical Therapy	-	-	-	-	-	Y
29		Occupational Therapy	-	-	-	-	-	Y
30		Speech-Language Pathology	-	-	-	-	-	Y
31			-	-	-	-	-	Y
32			-	-	-	-	-	Y
33			-	-	-	-	-	Y
34			-	-	-	-	-	Y
35		Non-Cost Settled Services						

Provider Name 0

Schedule C
Total Non-Allowable Expenses

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Out-of-State Travel	(5) Bad Debts	(6) In Kind	(7) Interest Expense	(8) Management Vehicles	(9) Program Income	(10) Restricted Donations	(11) Other Non-Allowables	(12) TOTAL
1		Region-Wide Indirect Administration									-
2		Local Clinical & Clerical Support									-
3		SCL Clinical & Clerical Support									-
4		Affiliate / Subcontract Support									-
5											-
6											-
7		DMS Cost Settled Services									
8		Individual Therapy									-
9		Group Outpatient Therapy									-
10		Mobile Crisis Services									-
11		Therapeutic Rehabilitation Services									-
12		Psychological Testing									-
13		Partial Hospitalization									-
14		Screening, Brief Intervention, and Referral to Treatment									-
15		Assertive Community Treatment									-
16		Intensive Outpatient Program Services									-
17		Residential Services for Substance Use Disorders									-
18		Residential Crisis Stabilization Services									-
19		Day Treatment									-
20		Peer Support Services									-
21		Comprehensive Community Support Services									-
22		Pregnant Women - Substance Use Prevention									-
23		Psychiatry and Medication Management									-
24		Primary Care Services									
25		Medical and Nursing Services									-
26		Laboratory									-
27		Radiology									-
28		Physical Therapy									-
29		Occupational Therapy									-
30		Speech-Language Pathology									-
31											-
32											-
33											-
34											-
35		Non-Cost Settled Services									
36		Outreach Services									-
37		Targeted Case Management (Substance Use Disorder)									-
38		Targeted Case Management (Severe MI or Child SED)									-
39		Targeted Case Management (MH / SU Disorder and CPHI)									-
40		Community Residential (Daily) MH									-
41		Community Residential (Daily) IDD									-
42		Transitional Living (SA Preg Women)									-
43		Transitional Living (SA)									-
44		Adult Day Training On-Site									-
45		Adult Day Training Off-Site									-
46		Transitional Living (SA Family Program)									-
47		DUI Assessment									-
48		PASRR									-
49		Respite									-

Provider Name 0

Schedule D
Total Units of Service

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Title XIX Fee-for-Service	(5) Title XIX Managed Care	(6) SCL	(7) Michelle P	(8) SCL CDO	(9) Michelle P CDO	(10) ET	(11) ABI	(12) DBHDID	(13) Others	(14) TOTAL
7		DMS Cost Settled Services											
8		Individual Therapy											-
9		Group Outpatient Therapy											-
10		Mobile Crisis Services											-
11		Therapeutic Rehabilitation Services											-
12		Psychological Testing											-
13		Partial Hospitalization											-
14		Screening, Brief Intervention, and Referral to Treatment											-
15		Assertive Community Treatment											-
16		Intensive Outpatient Program Services											-
17		Residential Services for Substance Use Disorders											-
18		Residential Crisis Stabilization Services											-
19		Day Treatment											-
20		Peer Support Services											-
21		Comprehensive Community Support Services											-
22		Pregnant Women - Substance Use Prevention											-
23		Psychiatry and Medication Management											-
24		Primary Care Services											
25		Medical and Nursing Services											-
26		Laboratory											-
27		Radiology											-
28		Physical Therapy											-
29		Occupational Therapy											-
30		Speech-Language Pathology											-
31													-
32													-
33													-
34													-
35		Non-Cost Settled Services											
36		Outreach Services											-
37		Targeted Case Management (Substance Use Disorder)											-
38		Targeted Case Management (Severe MI or Child SED)											-
39		Targeted Case Management (MH / SU Disorder and CPHI)											-
40		Community Residential (Daily) MH											-
41		Community Residential (Daily) IDD											-
42		Transitional Living (SA Preg Women)											-
43		Transitional Living (SA)											-
44		Adult Day Training On-Site											-
45		Adult Day Training Off-Site											-
46		Transitional Living (SA Family Program)											-
47		DUI Assessment											-
48		PASRR											-
49		Respite											-
50		Leisure Services											-
51		Supported Employment											-
52		Consultation & Education											-
53		DUI Education											-
54		Support Coordination (IDD)											-
55		Group Home											-
56		Specialized Services & Supplies											-
57		Adult Foster Care											-
58		Staffed Residence											-
59		Family Home Provider											-
60		Occupational Therapy											-
61		Physical Therapy											-
62		Speech Therapy											-
63		Behavior Support											-

Provider Name _____

Schedule E
Title XIX Cost Per Service

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Total DMS/MCO Cost (Apportioned)	(5) Total DMS/MCO Units of Service	(6) Cost Per Unit of Service
7		DMS Cost Settled Services			
8		Individual Therapy	-	-	0.00
9		Group Outpatient Therapy	-	-	0.00
10		Mobile Crisis Services	-	-	0.00
11		Therapeutic Rehabilitation Services	-	-	0.00
12		Psychological Testing	-	-	0.00
13		Partial Hospitalization	-	-	0.00
14		Screening, Brief Intervention, and Referral to Treatment	-	-	0.00
15		Assertive Community Treatment	-	-	0.00
16		Intensive Outpatient Program Services	-	-	0.00
17		Residential Services for Substance Use Disorders	-	-	0.00
18		Residential Crisis Stabilization Services	-	-	0.00
19		Day Treatment	-	-	0.00
20		Peer Support Services	-	-	0.00
21		Comprehensive Community Support Services	-	-	0.00
22		Pregnant Women - Substance Use Prevention	-	-	0.00
23		Psychiatry and Medication Management	-	-	0.00
24		Primary Care Services			
25		Medical and Nursing Services	-	-	0.00
26		Laboratory	-	-	0.00
27		Radiology	-	-	0.00
28		Physical Therapy	-	-	0.00
29		Occupational Therapy	-	-	0.00
30		Speech-Language Pathology	-	-	0.00
31			-	-	0.00
32			-	-	0.00

Provider Name 0

Schedule E-1
Title XIX Cost Apportionment

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Total DMS Units of Service	(5) Total MCO Units of Service	(6) Total Units All Payors	(7) DMS %	(8) MCO %	(9) Total Allowable Cost	(10) DMS Cost Apportioned	(11) MCO Cost Apportioned
7		DMS Cost Settled Services								
8		Individual Therapy	-	-	-	0.000000	0.000000	-	-	-
9		Group Outpatient Therapy	-	-	-	0.000000	0.000000	-	-	-
10		Mobile Crisis Services	-	-	-	0.000000	0.000000	-	-	-
11		Therapeutic Rehabilitation Services	-	-	-	0.000000	0.000000	-	-	-
12		Psychological Testing	-	-	-	0.000000	0.000000	-	-	-
13		Partial Hospitalization	-	-	-	0.000000	0.000000	-	-	-
14		Screening, Brief Intervention, and Referral to Treatment	-	-	-	0.000000	0.000000	-	-	-
15		Assertive Community Treatment	-	-	-	0.000000	0.000000	-	-	-
16		Intensive Outpatient Program Services	-	-	-	0.000000	0.000000	-	-	-
17		Residential Services for Substance Use Disorders	-	-	-	0.000000	0.000000	-	-	-
18		Residential Crisis Stabilization Services	-	-	-	0.000000	0.000000	-	-	-
19		Day Treatment	-	-	-	0.000000	0.000000	-	-	-
20		Peer Support Services	-	-	-	0.000000	0.000000	-	-	-
21		Comprehensive Community Support Services	-	-	-	0.000000	0.000000	-	-	-
22		Pregnant Women - Substance Use Prevention	-	-	-	0.000000	0.000000	-	-	-
23		Psychiatry and Medication Management	-	-	-	0.000000	0.000000	-	-	-
24		Primary Care Services								
25		Medical and Nursing Services	-	-	-	0.000000	0.000000	-	-	-
26		Laboratory	-	-	-	0.000000	0.000000	-	-	-
27		Radiology	-	-	-	0.000000	0.000000	-	-	-
28		Physical Therapy	-	-	-	0.000000	0.000000	-	-	-
29		Occupational Therapy	-	-	-	0.000000	0.000000	-	-	-
30		Speech-Language Pathology	-	-	-	0.000000	0.000000	-	-	-
31			-	-	-	0.000000	0.000000	-	-	-
32			-	-	-	0.000000	0.000000	-	-	-
33			-	-	-	0.000000	0.000000	-	-	-
34			-	-	-	0.000000	0.000000	-	-	-
35		Non-Cost Settled Services								
36		Outreach Services	-	-	-	0.000000	0.000000	-	-	-
37		Targeted Case Management (Substance Use Disorder)	-	-	-	0.000000	0.000000	-	-	-
38		Targeted Case Management (Severe MI or Child SED)	-	-	-	0.000000	0.000000	-	-	-
39		Targeted Case Management (MH / SU Disorder and CPHI)	-	-	-	0.000000	0.000000	-	-	-
40		Community Residential (Daily) MH	-	-	-	0.000000	0.000000	-	-	-
41		Community Residential (Daily) IDD	-	-	-	0.000000	0.000000	-	-	-
42		Transitional Living (SA Preg Women)	-	-	-	0.000000	0.000000	-	-	-
43		Transitional Living (SA)	-	-	-	0.000000	0.000000	-	-	-
44		Adult Day Training On-Site	-	-	-	0.000000	0.000000	-	-	-
45		Adult Day Training Off-Site	-	-	-	0.000000	0.000000	-	-	-

Provider Name 0

Schedule F
DBHDID Cost Per Service

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) Total DBHDID Cost (Apportioned)	(5) DBHDID Adjustments (Schedule F-2)	(6) Total DBHDID Allowable Expenses	(7) Total DBHDID Units of Service	(8) Cost per Unit of Service
7		DMS Cost Settled Services					
8		Individual Therapy	-	-	-	-	0.00
9		Group Outpatient Therapy	-	-	-	-	0.00
10		Mobile Crisis Services	-	-	-	-	0.00
11		Therapeutic Rehabilitation Services	-	-	-	-	0.00
12		Psychological Testing	-	-	-	-	0.00
13		Partial Hospitalization	-	-	-	-	0.00
14		Screening, Brief Intervention, and Referral t	-	-	-	-	0.00
15		Assertive Community Treatment	-	-	-	-	0.00
16		Intensive Outpatient Program Services	-	-	-	-	0.00
17		Residential Services for Substance Use Dis	-	-	-	-	0.00
18		Residential Crisis Stabilization Services	-	-	-	-	0.00
19		Day Treatment	-	-	-	-	0.00
20		Peer Support Services	-	-	-	-	0.00
21		Comprehensive Community Support Service	-	-	-	-	0.00
22		Pregnant Women - Substance Use Preventi	-	-	-	-	0.00
23		Psychiatry and Medication Management	-	-	-	-	0.00
24		Primary Care Services					
25		Medical and Nursing Services	-	-	-	-	0.00
26		Laboratory	-	-	-	-	0.00
27		Radiology	-	-	-	-	0.00
28		Physical Therapy	-	-	-	-	0.00
29		Occupational Therapy	-	-	-	-	0.00
30		Speech-Language Pathology	-	-	-	-	0.00
31			-	-	-	-	0.00
32			-	-	-	-	0.00
33			-	-	-	-	0.00
34			-	-	-	-	0.00
35		Non-Cost Settled Services					
36		Outreach Services	-	-	-	-	0.00
37		Targeted Case Management (Substance Us	-	-	-	-	0.00
38		Targeted Case Management (Severe MI or	-	-	-	-	0.00
39		Targeted Case Management (MH / SU Diso	-	-	-	-	0.00
40		Community Residential (Daily) MH	-	-	-	-	0.00
41		Community Residential (Daily) IDD	-	-	-	-	0.00

Provider Name 0

Schedule F-1
DBHDID Cost Apportionment

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Cost Center Description Title	(4) DBHDID Units of Service	(5) Total Units All Payors	(6) DBHDID %	(7) Total Allowable Cost	(8) DBHDID Cost Apportioned
7		DMS Cost Settled Services					
8		Individual Therapy	-	-	0.000000	-	-
9		Group Outpatient Therapy	-	-	0.000000	-	-
10		Mobile Crisis Services	-	-	0.000000	-	-
11		Therapeutic Rehabilitation Services	-	-	0.000000	-	-
12		Psychological Testing	-	-	0.000000	-	-
13		Partial Hospitalization	-	-	0.000000	-	-
14		Screening, Brief Intervention, and Referral to Treatment	-	-	0.000000	-	-
15		Assertive Community Treatment	-	-	0.000000	-	-
16		Intensive Outpatient Program Services	-	-	0.000000	-	-
17		Residential Services for Substance Use Disorders	-	-	0.000000	-	-
18		Residential Crisis Stabilization Services	-	-	0.000000	-	-
19		Day Treatment	-	-	0.000000	-	-
20		Peer Support Services	-	-	0.000000	-	-
21		Comprehensive Community Support Services	-	-	0.000000	-	-
22		Pregnant Women - Substance Use Prevention	-	-	0.000000	-	-
23		Psychiatry and Medication Management	-	-	0.000000	-	-
24		Primary Care Services					
25		Medical and Nursing Services	-	-	0.000000	-	-
26		Laboratory	-	-	0.000000	-	-
27		Radiology	-	-	0.000000	-	-
28		Physical Therapy	-	-	0.000000	-	-
29		Occupational Therapy	-	-	0.000000	-	-
30		Speech-Language Pathology	-	-	0.000000	-	-
31			-	-	0.000000	-	-
32			-	-	0.000000	-	-
33			-	-	0.000000	-	-
34			-	-	0.000000	-	-
35		Non-Cost Settled Services					
36		Outreach Services	-	-	0.000000	-	-
37		Targeted Case Management (Substance Use Disorder)	-	-	0.000000	-	-
38		Targeted Case Management (Severe MI or Child SED)	-	-	0.000000	-	-
39		Targeted Case Management (MH / SU Disorder and CPHI)	-	-	0.000000	-	-

Provider Name 0

Schedule F-2
DBHDID Adjustments

For the Period January 0, 1900 through January 0, 1900

(1) Ln #	(2) Unit Code #	(3) Explanation for Adjustment	(4) Work Paper Ref	(5) Schedule F Line #	(6) Increase	(7) (Decrease)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14		**GRAND TOTALS**			0	0

Provider Name _____

Schedule G

For the Period January 0, 1900 through January 0, 1900

Grant Identification

(1) Grant #	(2) Description of Grant	(3) Source of Grant	(4) Total Dollar Amount of Grant