

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC COST REPORT INSTRUCTIONS

February 1, 2024

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General Instructions

Introduction

This document provides guidance to CCBHCs on how to use the Certified Community Behavioral Health Clinic (CCBHC) cost report for the four Certified Clinic Prospective Payment System (CC PPS) rate methodologies—CC PPS-1, CC PPS-2, CC PPS-3 and CC PPS-4. The cost report may be used to determine the clinic-specific PPS rate and to annually report demonstration costs. These payment rates were provided through the Demonstration Program to Improve Community Mental Health Services, which was created under Section 223 of the Protecting Access to Medicare Act of 2014. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law.

Instructions for Completing the Cost Report

The cost report contains tabs as described in Table 1: Worksheet Contents:

Table 1: Worksheet Contents

Tab Name	Tab Color	Purpose	PPS Methodology	Requirement Information
A.1. Provider Information	Light Blue	Provider Data	All	Required
B.1. Trial Balance	Dark Green	Direct and indirect trial balance expenses, including reclassified, adjusted, and anticipated costs	All	Required
B.2. Trial Balance Crisis	Dark Green	Direct costs for special crisis service rate development	CC PPS-3 and CC PPS-4	Required
B.3. Trial Balance Reclassifications	Dark Green	Reclassification entries and explanations	All	Required
B.4. Trial Balance Adjustments	Dark Green	Adjustment entries and explanations	All	Required
C.1. Anticipated Costs	Tan	Anticipated changes to expenses for adding CCBHC services not previously provided	All	Optional
D.1. Indirect Cost Allocation	Red	Method for allocation of indirect costs to CCBHC services	All	Required

Tab Name	Tab Color	Purpose	PPS Methodology	Requirement Information
A.2. Allocation Descriptions	Light Blue	Narratives describing justification for allocations of costs	All	Required
E.1. Daily Visits PPS-1	Light Green	Visit data for CCBHCs for the CC PPS-1 method	CC PPS-1	Required for CC PPS-1
E.2. Monthly Visits PPS-2	Light Green	Visit data for CCBHCs for the CC PPS-2 method	CC PPS-2	Required for CC PPS-2
E.3. Daily Visits PPS-3	Light Green	Visit data for CCBHCs for the CC PPS-3 method	CC PPS-3	Required for CC PPS-3
E.4. Monthly Visits PPS-4	Light Green	Visit Data for the CCBHCs for the CC PPS-4 method	CC PPS-4	Required for CC PPS-4
A.3. Services Provided	Light Blue	Services provided and FTEs by position for CCBHC services	Either	Required
F.1. CC PPS-1 Rate	Dark Blue	Determination of rates for the CC PPS-1 method using total allowable costs	CC PPS-1	Required for CC PPS-1
F.2. CC PPS-2 Rate	Dark Blue	Determination of rates for the CC PPS-2 method using cost allocation by recipient categories	CC PPS-2	Required for CC PPS-2
F.3. CC PPS-3 Rate	Dark Blue	Determination of rates for the CC PPS-3 method using total allowable costs	CC PPS-3	Required for CC PPS-3
F.4. CC PPS-4 Rate	Dark Blue	Determination of rates for the CC PPS-4 method using cost allocation by recipient categories	CC PPS-4	Required for CC PPS-4
A.4. Comments	Light Blue	Additional considerations in developing PPS rates	All, as needed	Optional
A.5. Certification	Light Blue	Certification statement	All	Required

Abbreviations: CCBHC, Certified Community Behavioral Health Clinic; CC PPS, Certified Clinic Prospective Payment System; FTE, full-time equivalent

This document provides instructions for completing each tab of the cost report. These instructions are not intended to be all-encompassing. The cost report should be based on the CCBHC financial and statistical records. All reported amounts must allow for reconciliation to the CCBHC's general ledger and audited financial statements.

When reporting costs, the CCBHC must adhere to the 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards and 2 CFR §200 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. The CCBHC records must be detailed, orderly, complete, and available for review or audit. It is important that supporting documentation be maintained for all costs reported; the cost report package and source documentation (e.g., invoices, patient records, cancelled checks) must adhere to federal and state record retention requirements.

A Comments worksheet is built into the cost report. This tab is not formatted; instead, it provides CCBHCs with an opportunity to submit comments in any format. For example, narrative text, small tables, or exhibits can be included here. In addition to the cost report, documentation that provides additional information is encouraged in order to support full disclosure.

The recommended order for completing the cost report is in Table 2: Recommended Order:

Table 2: Recommended Order

Schedule	Instructions
Provider Information	Read section 2, and complete entire tab
Trial Balance (columns 1 through 3)	Read section 3, and complete columns 1 and 2 for all lines
Trial Balance Reclassifications	Read section 5, and complete entire tabs
Trial Balance (columns 4 and 5)	
Trial Balance Adjustments	Read section 6, and complete entire tab
Trial Balance (columns 6 and 7)	
Anticipated Costs	Read section 7, and complete entire tab
Trial Balance (columns 8 and 9)	
Trial Balance Crisis	Read section 5, and complete entire tab
Indirect Cost Allocation	Read section 7, and complete entire tab
Allocation Description	Read section 9, and complete entire tab
Daily Visits PPS-1, Monthly Visits PPS-2, Daily Visits PPS-3 or Monthly Visits PPS-4	Read section 10, 11, 12, or 13 and complete applicable tab
Services Provided	Read section 14, and complete entire tab
Comments (as needed)	Read section 15, and complete entire tab
CC PPS-1 Rate or CC PPS-2 Rate, CC PPS-3 Rate, CC PPS-4 Rate	Read section 16, 17, 18 or 19 and complete applicable tab
Certification	Read section 20, and complete entire tab

If the CCBHC's records are maintained on an accounting basis other than accrual, adjustments to convert to an accrual basis of accounting are required. The accrual basis of accounting is considered the most accurate method for determining costs during a period of time.

All information requested in the tabs must be furnished unless the information does not apply to a specific CCBHC because of organizational structure or the choice of PPS methodology. Failure to complete applicable tabs properly will result in rejection of the cost report and its return to the CCBHC

for correction and resubmission. CCBHCs should round monetary amounts to the nearest whole dollar; round amounts of \$0.50 or more up to the next dollar, and round amounts of \$0.49 or less down. Standard (i.e., preprinted) line numbers and expense category descriptions cannot be changed.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, individuals are not required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148, and the CMS ID number is CMS-10398 (#43). The time required to complete this information collection is estimated to average 54 hours for PPS-1, 109 hours for PPS-2, 70 hours for PPS-3 and 129 hours for PPS-4 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Definitions of Selected Terms

The following key terms associated with cost report and these instructions are defined below:

ADMINISTRATIVE COSTS: General administration and general expenses such as the director's office, accounting, personnel, and all other types of expenditures not listed specifically under one of the subcategories of "Facilities".

ALLOWABLE COSTS: Costs permitted for Medicaid reimbursement under 45 CFR §75 and 2 CFR §200.

ANTICIPATED COSTS: Anticipated expenses for the rate year, including personnel costs, facility costs, technology costs, supplies and materials costs, training and development costs not included in actual costs in the reporting period.

CCBHC COSTS UNDER AGREEMENT: Costs charged to the CCBHC for services that are furnished under an agreement with a Direct Collaborating Organization (DCO).

CRISIS STABILIZATION: On-site services that are designed to help individuals who are experiencing a mental health or substance use crisis to de-escalate and return to a stable state.

DIRECT COSTS (allowable): Costs that can be identified specifically with a particular final cost objective, such as a Federal award, or other internally or externally funded activity, or that can be directly assigned to such activities relatively easily with a high degree of accuracy. Costs incurred for the same purpose in like circumstances must be treated consistently as either direct or indirect (F&A) costs¹.

DIRECT COSTS FOR CCBHC SERVICES: Direct costs attributed to services and activities covered by the state's scope of services for CCBHC and included in the CC PPS rate.

¹ 2 CFR 200.413(a)

DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES & NON-REIMBURSABLE

COSTS: Direct costs attributed to services and activities not covered by the state's scope of services for CCBHC, including costs for services and activities that are reimbursed outside of the CC PPS rate and unallowable costs.

INDIRECT COSTS: Costs for facility and administration not classified as direct costs. See 2 CFR § 200.414.

MOBILE CRISIS 9813: Intervention service provided to individuals experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting that meet the qualifying criteria specified in Section 9813 of the American Rescue Plan Act

MOBILE CRISIS NON-9813: Intervention service provided to individuals experiencing a mental health or substance use disorder crisis outside of a hospital or other facility setting.

PPS METHODOLOGY: Method of reimbursement that pays CCBHCs a fixed amount per day or per month for each Medicaid beneficiary who receives CCBHC services.

PPS-1 RATE METHODOLOGY: Daily clinic-specific PPS rate composed of all CCBHC Services CCBHC costs and visits for CCBHC services covered under a state's CCBHC scope of services.

PPS-2 RATE METHODOLOGY: Monthly clinic-specific PPS rate composed of all CCBHC costs and visits covered under a state's CCBHC scope of services.

PPS-3 RATE METHODOLOGY: Daily clinic-specific PPS rates composed of all CCBHC costs and visits for Special Crisis Services (SCS) and Non-SCS rates, as identified in a state's CCBHC scope of services.

PPS-4 RATE METHODOLOGY: Monthly clinic-specific PPS rates composed of all CCBHC costs and visits for SCS and Non-SCS services as identified in a state's CCBHC scope of services.

SITE COSTS: Facility costs classified as indirect costs including depreciation on buildings, equipment and capital improvement, interest on debt associated with certain buildings, equipment and capital improvements, and operations and maintenance expenses.

STATE CCBHC SCOPE OF SERVICES: The comprehensive set of mental health and substance use disorder services aligned with the nine required services, defined in the PAMA Act, Section 223, for certification that should be available to all residents of a community, regardless of their income or insurance status, to be included in the CC PPS rate. The scope of services should include the procedure codes that may be billable as a visit as well as the activities required for certification and delivery of the nine required services.

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Provider Information Tab

Use the Provider Information tab to report CCBHC-identifying information for all of the CCBHC's primary and satellite center locations that are included in the demonstration agreement. The CCBHC must complete every applicable item in this tab. Part 1 includes information about single sites or, for clinics filing under consolidated cost reporting, about the central office. Only clinics filing under consolidated reporting need to fill out Part 2—it is for site-specific information.

MEDICAID ID: Enter the primary center's Medicaid Identification Number. This will be either the Centers for Medicare & Medicaid Services (CMS) Certification Number (CCN) or other ID assigned.

NATIONAL PROVIDER IDENTIFIER: Enter the primary center's National Provider Identifier (NPI).

Note: The purpose of the Medicaid ID and NPI is to identify the cost report information for each individual CCBHC, regardless of the number of satellites or services associated with that clinic.

REPORTING PERIOD: After "From:" enter the beginning date of the reporting period for which the current information is being provided. Use the MM/DD/YYYY format (e.g., 07/01/2013). After "To:" enter the ending date of the period for which the current information is being provided. Use the MM/DD/YYYY format (e.g., 06/30/2014).

RATE PERIOD: After "From:" enter the beginning date on which the PPS rate will take effect. Use the MM/DD/YYYY format (e.g., 07/01/2013). After "To:" enter the date the on which PPS rate will expire. Use the MM/DD/YYYY format (e.g., 06/30/2014).

Note: The identifying information (Medicaid ID, NPI, Reporting Period, and Rate Period) in the Provider Information tab will automatically populate items in the other tabs on the basis of the entries made on this page.

Select Type of Oversight: This section is for documenting the level of oversight and is for state use only. Do not make any entries in this section.

PPS Methodology: Enter the PPS methodology that the CCBHC will use for the demonstration. Enter either CC PPS-1, CC PPS-2, CC PPS-3, or CC PPS-4.

PART 1 – PROVIDER INFORMATION (Consolidated)

For central office locations not providing services, skip questions 6, 7, and 10–14. For single sites or central offices providing services, complete all questions.

- Line 1:** Enter the official name as it appears on the license or official CCBHC letterhead. If the cost report is for multiple sites or for clinics filing as a consolidated entity, name each site separately in Part 2.
- Line 2:** Enter the official street address or P.O. Box as it appears on the license or official CCBHC letterhead.

- Line 3:** Enter the official city, state, and ZIP Code as they appear on the license or official CCBHC letterhead.
- Line 4:** Enter the county as it appears on the license or official CCBHC letterhead.
- Line 5:** The Medicaid ID for the primary center or headquarters will populate automatically from the Medicaid ID entered at the top of this worksheet.
- Line 6:** The NPI for the primary center or headquarters will populate automatically from the NPI entered at the top of this worksheet.
- Line 7:** Enter the description that reflects the CCBHC's headquarter location designation as Urban, Rural, or Unknown.
- Line 8:** Enter the code for the description that represents the CCBHC's organizational authority (i.e., the ownership or auspices of the CCBHC) from Table 3: Organizational Authority Codes:

Table 3: Organizational Authority Codes

Code	Organizational Authority Description
1	Nonprofit
2	Local government behavioral health authority
3	Indian Health Service organization
4	Indian tribe or tribal organization
5	Urban Indian organization

- Line 9:** Enter the names and the NPI of all (1) behavioral health professionals who provide services directly at the CCBHC and (2) providers who have DCO relationships with the CCBHC. Enter the names in column 1 and the corresponding NPI in column 2. Use lines 9a–9o for this information. If additional behavioral health professionals are needed, in 9o, enter “see additional information in the comments tab” and continue listing the names and NPIs in the comments tab until all behavioral health professionals are identified. A clinic must report all provider NPIs to the extent available. If no NPI is available, leave column 2 blank.
- Line 10:** Enter “Yes” if the CCBHC is certified and currently paid under the Medicaid Clinic Services Benefit described in Social Security Act §1905(a)(9). Otherwise, enter “No.” Examples of additional certification include, but are not limited to, Federally Qualified Health Clinic (FQHC), Rural Health Clinic (RHC), or Behavioral Health Home.
- Line 11:** Enter “Yes” if the site operates as other than a CCBHC. Otherwise, enter “No.” If No is entered, skip lines 12 and 14.
- Line 12:** If the answer to line 11 is Yes (the site operates as other than a CCBHC), describe the type of operation by entering Clinic, FQHC, or Other. If the answer to line 11 is No, skip this line.
- Line 13:** Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Clinic hours, outside of the 24-hour mobile crisis team, should be reported to help evaluate access to care.
- Line 14:** If the answer to Line 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the

site operates as a CCBHC and other than a CCBHC during the same time period. If the answer to line 12 is No, skip this line.

Line 15: List any excluded satellite facilities and reasons for exclusion.

Line 16: Enter “Yes” if the site is filing a consolidated cost report for multiple locations, and proceed to Part 2. Enter “No” if the site is *not* filing a consolidated cost report for multiple locations, and proceed to the Trial Balance tab.

Line 17: If line 16 was “Yes,” enter the number of sites included in the cost report. For each site, copy and complete Part 2 below.

PART 2 – PROVIDER INFORMATION FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING

Each clinic filing under consolidated cost reporting must complete this section of the worksheet. Complete Part 2 for *each site* included in the consolidation. When more than one satellite site exists, create a new tab within the workbook labeled “Provider Information Cont.”. For each satellite site copy and paste all of Part 2 into the new tab and complete the form. Indicate on lines 6 and 7 of each copy of Part 2 the corresponding Medicaid ID and NPI under which the site is certified. Do not re-enter clinic information for the central office that has already been entered in the Provider Information tab in Part 1.

Line 1: Enter “Yes” if the site was in existence before April 1, 2014, and enter “No” if the site was not in existence before April 1, 2014. If Yes is entered, complete all questions in Part 2. If No is entered, complete only lines 2–6 and make sure that the site is documented in Part 1, line 16. It is important to note that *no payment will be made to satellite facilities of CCBHCs established after April 1, 2014. Classify costs associated with facilities established after April 1, 2014, as costs other than CCBHC services on the Trial Balance and the Trial Balance Reclassifications tabs.*

Line 2: Enter the official name of the satellite site.

Line 3: Enter the official street address or P.O. Box of the satellite site.

Line 4: Enter the official city, state, and ZIP Code of the satellite site.

Line 5: Enter the county of the satellite site.

Line 6: Enter the Medicaid ID of the satellite facility.

Line 7: Enter the NPI of the satellite facility.

Line 8: Enter the description that reflects the satellite site’s location designation as Urban, Rural, or Unknown.

Line 9: Enter the code for the description that represents the CCBHC’s organizational authority (i.e., the ownership or auspices of the CCBHC) from Table 4: Organizational Authority Codes.

Table 4: Organizational Authority Codes

Code	Organizational Authority Description
1	Nonprofit
2	Local government behavioral health authority
3	Indian Health Service organization
4	Indian tribe or tribal organization
5	Urban Indian organization

- Line 10:** Enter “Yes” if the CCBHC is certified and currently paid under the Medicaid Clinic Services Benefit described in Social Security Act §1905(a)(9). Otherwise, enter “No.”
- Line 11:** Enter “Yes” if the site operates as other than a CCBHC. Otherwise, enter “No.” If No is entered, skip lines 12 and 14.
- Line 12:** If the answer to line 11 is Yes (the site operates as other than a CCBHC), describe the type of operation by entering Clinic, FQHC, or Other. If the answer to line 11 is No, skip this line.
- Line 13:** Enter the hours of operation and the total hours for each day of the week that the site operates as a CCBHC. Clinic hours, outside of the 24 hour mobile crisis team, should be reported to help evaluate access to care.
- Line 14:** If the answer to 11 is Yes (the site operates as other than a CCBHC), enter the hours of operation and the total hours for each day of the week that the site operates as other than a CCBHC. Note, the hours provided in line 13 and 14 may overlap if the site operates as a CCBHC and other than a CCBHC over the same time period. If the answer to 11 is No, skip this line.

3

Trial Balance Tab

Use the Trial Balance tab (1) to record amounts from the trial balance expense accounts from your books and records, (2) to perform the necessary reclassification and adjustments to adhere to Medicare and Medicaid cost principles, and (3) to record estimates of anticipated changes in costs. All expense categories listed do not apply to all CCBHCs using this worksheet. Where expense categories are not applicable, enter 0.

If the cost elements of an expense category are maintained separately on your books, you must reconcile the costs on your accounting books and records to those on this worksheet and maintain documentation of that reconciliation. These materials are subject to review or audit.

Also, submit the working trial balance of the site with the cost report. A *working trial balance* is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns. It is used as a basic summary for financial statements.

PART 1 – DIRECT CCBHC EXPENSES

Column Descriptions

- Columns 1–2:** Enter total expenses incurred during the reporting period on the appropriate lines in columns 1 and 2. Categorize the expenses as Compensation (column 1) and Other (column 2). The expenses listed in these columns must agree with those listed in your accounting books and records. Total compensation for an individual would include their total compensation package and not any type of proration of fringe benefits based on salary costs.
- Column 3:** “Total,” which is calculated by adding the entries in columns 1 and 2 to the left, is automatically populated in this column.
- Column 4:** Enter any reclassification among expense category expenses that are needed to achieve proper cost allocation. List information about the reclassification entries in column 4 on the Trial Balance Reclassifications tab.
Note: The net total of the entries in column 4 must equal zero on line 53.
- Column 5:** “Reclassified trial balance,” which is calculated by using column 3 totals and column 4 reclassifications, is automatically populated in this column. The total on line 53 in column 5 must equal the total on line 53 in column 3.
- Column 6:** Enter the amounts of any adjustments to expenses indicated on the Trial Balance Adjustments tab on the appropriate lines in column 2. The total on the Trial Balance tab on line 53 in column 6 must equal the amount on the Trial Balance Adjustments tab on line 22 in column 2.
- Column 7:** “Adjusted amount,” which is calculated by adjusting the amounts in column 5 by the amounts in column 6 (increases or decreases), is automatically populated in this column.

Column 8: Enter the amounts of any anticipated cost indicated in the Anticipated Costs tab on the appropriate lines in column 4. The total amount on the Trial Balance tab on line 53 in column 8 should equal the amount on the Anticipated Costs tab on line 53 in column 4.

Column 9: "Net expenses," which is calculated by adjusting the amounts in column 7 by the amounts in column 8 (increases or decreases), is automatically populated in this column.

Line Descriptions

PART 1A – CCBHC STAFF COSTS

Lines 1–16: Enter the cost information for health care staff on the appropriate line by type of staff in columns 1–8, as described above.

Line 17: Enter a subtotal of costs for all other appropriate staff not listed on lines 1–16, and specify in the Comments tab.

Line 18: "Subtotal staff costs," which is calculated by adding the amounts on lines 1–17 above, is automatically populated on this line.

PART 1B – CCBHC COSTS UNDER AGREEMENT

Line 19: Enter the cost of CCBHC services furnished under agreement with DCOs.

Line 20: Enter any other expenses directly related to providing CCBHC services furnished under agreement with DCOs. For example, if a 24-hour mobile crisis service is furnished under agreement and mileage charges are billed separately, enter the expenses here and specify on the Comments tab.

Line 21: "Subtotal costs under agreement," which is calculated by adding the amounts on lines 19–20 above, is automatically populated on this line.

PART 1C – OTHER DIRECT CCBHC COSTS

Lines 22–26: Enter direct expenses related to providing CCBHC-covered services. Leave column 1 blank. In column 2, enter all costs related to the expenses specified. If these costs are used to provide both CCBHC and non-CCBHC services, reclassify the non-CCBHC cost apportionment under column 4 to lines 50 or 51, as appropriate. Include the allocation description on the Trial Balance Reclassifications tab.

Line 27: Enter a subtotal of all net costs for other categories not listed on lines 22–26, and specify in the Comments tab.

Line 28: "Subtotal other direct CCBHC costs," which is calculated by adding the amounts on lines 22–28 above, is automatically populated on this line.

Line 29: "Total cost of CCBHC services," which is calculated by adding the amounts on lines 18, 21, and 28 above, is automatically populated on this line.

PART 2 – INDIRECT COSTS

PART 2A: SITE COSTS

Lines 30–37: Enter the overhead expenses related to the site.

Line 38: Enter a subtotal of all other overhead facility expenses and describe the expenses with amounts in the Comments tab.

Line 39: “Other site costs,” which is calculated by adding lines 30–37 above, is automatically populated on this line.

PART 2B: ADMINISTRATIVE COSTS

Lines 40–46: Enter the overhead expenses related to administration and management of the clinic.

Line 47: Enter a subtotal of all other overhead administrative expenses and describe the expenses with amounts in the Comments tab.

Line 48: “Subtotal administrative costs,” which is calculated by adding the amounts in lines 40–47, is automatically populated in this line.

Line 49: “Total overhead,” which is calculated by adding lines 39 and 48, is automatically populated on this line.

PART 3 – DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A: DIRECT COSTS FOR SERVICES OTHER THAN CCBHC SERVICES

Line 50: Enter the subtotal of direct costs for services provided for 988 response system programs, funded through the state or a federal grant program and not including costs for services funded through CCBHC CC PPS rates.

Line 51: Enter the subtotal of direct costs for non-CCBHC services covered (allowable) by Medicaid, excluding overhead and specify in the Comments tab.

PART 3B: NON-REIMBURSABLE COSTS

Line 52: Enter the subtotal of direct costs for non-CCBHC services not reimbursable (unallowable) by Medicaid, and specify in the Comments tab.

Line 53: “Subtotal costs for non-CCBHC services,” which is calculated by adding the amounts on lines 50, 51 and 52 above, is automatically populated on this line.

Line 54: “Total costs,” which is calculated by adding line 29, line 49, and line 53 above, is automatically populated on this line.

4

Trial Balance Crisis Tab

The Trial Balance Crisis tab separates costs by each special crisis service (i.e., Mobile Crisis 9813, Mobile Crisis Non-9813, Crisis Stabilization) as well as Non-Crisis PPS in columns 1-4. Enter the appropriate information into at least one SCS column and the Non-Crisis column. States should inform the CCBHC which SCS rates are applicable in that state. If a state chooses not to use all three SCS rates, the direct costs for the unused SCS category should be included in column 4, non-crisis for inclusion in the non-SCS CC PPS rate.

Use the Trial Balance Crisis tab (1) to record amounts from the trial balance expense accounts from your books and records, (2) to perform the necessary reclassification and adjustments to adhere to Medicare and Medicaid cost principles, and (3) to record estimates of anticipated changes in costs. All expense categories listed do not apply to all CCBHCs using this worksheet. Where expense categories are not applicable, enter 0.

If the cost elements of an expense category are maintained separately on your books, you must reconcile the costs on your accounting books and records to those on this worksheet and maintain documentation of that reconciliation. These materials are subject to review or audit.

Also, submit the working trial balance of the site with the cost report. A *working trial balance* is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns. It is used as a basic summary for financial statements. .

Line Descriptions

Line descriptions correspond to the Trial Balance tab line descriptions described in Section 3.

5

Trial Balance Reclassifications Tab

Use the Trial Balance Reclassifications tab for reclassifying certain amounts to determine the proper cost allocation. The expense categories that are affected (listed under the Description column in the Trial Balance tab) must be specifically identifiable in your accounting records. Use reclassifications when expenses that are applicable to more than one of the expense categories listed in the Trial Balance tab are maintained in your accounting books and records under a single expense category.

For example, if a psychiatrist performs administrative duties, the appropriate portion of his or her compensation, payroll taxes, and fringe benefits must be reclassified from "Psychiatrist" on line 1 to "Office salaries" on line 40 on the Trial Balance tab. On the Trial Balance Reclassifications tab, the amount on line 36 in column 3 must be equal to the amount on line 36 in column 6.

When reclassifying costs for allocation purposes, add a narrative detailing the calculations and methods to support the allocation methodology in the appropriate section of Allocation Descriptions tab (See Section 9, the Direct Costs Allocation tab, for more information).

The totals from column 3 and column 6 should be transferred to the appropriate line items in column 4 of the Trial Balance tab when completed.

6

Trial Balance Adjustments Tab

Use the Trial Balance Adjustments tab for adjusting the expenses listed in the Trial Balance tab in column 6 (Adjustments). Make these adjustments on the basis of either cost or amount received. To indicate the basis for adjustments in column 1, enter “A” for cost; if cost cannot be determined, enter “B” for amount received. Once an adjustment to an expense is made on the basis of cost, you may not adjust the expense on the basis of revenue in future cost-reporting periods. If total direct and indirect cost can be determined, use cost for the basis of the adjustment. Enter revenue as the basis for the adjustment only if the cost (including the direct cost and all applicable overhead) cannot be determined.

Types of items to be entered on this table include (1) those that are needed to adjust expenses incurred; (2) those that constitute recovery of expenses through sales, charges, fees, and so forth; and (3) those that are needed to adjust expenses in accordance with cost principles described in 45 CFR §75.

If an adjustment to an expense affects more than one expense category, record the adjustment to each expense category on a separate line on this worksheet. For example, if the CCBHC leases space or equipment from a related party, the lease expenses must be adjusted to reflect only the depreciation expenses related to the leased asset.

Home office adjustments must be described in the Allocation Descriptions tab (if applicable).

Certain Line Descriptions

Most line descriptions are self-explanatory. However, guidance is provided for selected lines below.

PART 1 – COMMON ADJUSTMENTS

- Line 1:** Investment income on restricted and unrestricted funds that are commingled with other funds must be applied together against the total interest expense included in allowable costs. Apply these commingled investment funds against appropriate expense categories such as administrative, depreciation of buildings and fixtures, or depreciation of equipment on the basis of the ratio of the interest expense charged to each expense category to the total interest expense charged to all of your expense categories.
- Line 5:** Enter the allowable home office costs allocated to the site.
- Line 8:** Enter the amount of allowable cost of the services furnished by National Health Service Corps (NHSC) personnel.
- Lines 9–10:** If depreciation expenses computed in accordance with the cost principles at 45 CFR §75 differ from depreciation expenses in your books, enter the difference on line 9 (building and fixtures) or line 10 (equipment).
- Line 11:** Enter a subtotal of all other adjustments and describe the adjustments and amounts in the Comments tab.

Line 12: “Subtotal of common adjustments,” which is calculated by adding lines 1 through 11, is automatically populated on this line.

PART 2 – COSTS NOT ALLOWED

Lines 13–21: Enter expenses not allowed from federal funding as identified in 45 CFR §75. These costs should be subtracted from the applicable line items in the Trial Balance tab. An example of other costs not allowed are certain costs associated with related parties, such as rent expense. Rent expense from a related party must be adjusted to the depreciable amount for the building, as per 45 CFR 75.465.

Line 22: Enter a subtotal of all other costs not allowed and describe the costs not allowed with amounts in the Comments tab.

Line 23: “Subtotal of costs not allowed adjustments,” which is calculated by adding lines 13 through 22, is automatically populated on this line.

Line 24: “Total adjustments,” which is calculated by adding lines 12 and 23, is automatically populated on this line.

When complete, transfer the amounts from column 2 in this tab to the appropriate line in column 6 in the Trial Balance tab.

7

Anticipated Costs Tab

Use the Anticipated Costs tab to add or change the expenses listed on Trial Balance tab, column 8. Anticipated costs are (1) additional costs related to services that were not previously offered but that CCBHCs are required to offer or (2) costs that are expected to increase as a result of offering CCBHC services during the rate period that were not captured in the reporting period. The costs should be to support both Medicaid and non-Medicaid users. Anticipated costs are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.

Column Descriptions

- Column 1:** Enter the change in the number of full-time equivalent (FTE) staff members needed to provide CCBHC services. Enter the number as either a positive number for increases in FTE or a negative number for decreases in FTE. For instance, if an additional psychiatric nurse is required to offer CCBHC services, enter a 1 on line 2, column 1.
- Column 2:** Enter the additional expenses associated with providing new or expanded CCBHC services. The amount entered should be the additional cost expected that is not already accounted for in the Trial Balance.
- Column 3:** Enter amounts that are expected to decrease as a result of the provision of CCBHC services. For instance, if a staff member providing case management services for non-CCBHC services is repurposed to provide case management for CCBHC services, there should be a positive expense amount on line 6, column 2, and a negative expense amount on line 51, column 3.

Line Descriptions

Line descriptions correspond to the Trial Balance tab line description described in Section 3.

8

Indirect Cost Allocation Tab

Use the Indirect Cost Allocation tab to identify the method used for calculating allocable indirect costs to CCBHC services. This cost report allows a clinic to identify indirect cost using (1) an indirect rate approved by a cognizant agency, (2) a 10 percent rate, (3) calculated indirect cost allocable to CCBHC services, or (4) other method.

This tab uses a hierarchical calculation to determine which method is used and which amount will be included in the PPS rate formula, carried forward from line 16. For example, if “yes” is entered in line 1, the amount from line 5 will be used in the PPS rate formula and show in line 16. If “no” or nothing is entered in line 1 and “yes” is entered into line 7, then line 10 will be used in the PPS rate formula and show in line 16. If “no” or nothing is entered in lines 1 and 7, and “yes” is entered in line 11, then line 14 will be used in the PPS rate formula and show in line 16. If “yes” is not found in lines 1, 7 or 11, then the amount in line 15 will be used in the PPS rate formula and show in line 16.

Line Descriptions

- Lines 1–2:** If the organization has an indirect rate approved by a cognizant agency, enter “Yes,” and enter the cognizant agency on line 2. The following rules apply to the use of approved indirect cost rate agreements:
- Non-profit organizations with no Federal funding are not required to negotiate a federally approved rate. Pass-through entities, such as state governments, are required to either negotiate a rate with the non-profit or provide the minimum rate of 10% described in line 7.
 - Non-profit organizations with Federal funding should either use the rate negotiated with the agency that provides the most funding or, if they qualify, the minimum rate of 10% described in line 7.
 - State governments, local governments, or tribal agencies with less than \$35 million in direct Federal funding are required to prepare an annual indirect cost rate proposal and keep it on file. If a Federal rate agreement has never been filed, the state or local government may opt for the minimum rate of 10% described in line 7.
 - State or local governments with at least \$35 million in direct Federal funding must obtain a federally approved rate agreement and use the agreed upon rate here.
- If the organization does not have an approved indirect cost rate, enter “No” and proceed to line 7.
- Line 3:** Describe the basis for calculating the indirect cost rate. Identify the line numbers from the Trial Balance tab used in determining the base. If more space is needed for a complete description, include additional information in the Comments tab.
- Line 4:** Enter the cost basis described on line 3 above as a whole dollar amount.
- Line 5:** Enter the allocation rate percentage subject to the agreement.

- Line 6:** “Calculated indirect costs allocable to CCBHC services,” which is calculated by multiplying lines 4 and 5 above, is automatically populated on this line. If line 6 is greater than zero, no additional information is needed in this tab.
- Line 7:** If the organization is qualified and chooses to use the minimum rate, enter “Yes” and review lines 8–10. If not, enter “No” and go to question 11.
- Pursuant to 45 CFR 75.414(f), to qualify for the minimum rate, the organization must be a nonfederal entity that has never received a negotiated indirect cost rate and that receives less than \$35 million in direct federal funding. The organization may then elect to use the minimum rate of 10 percent of modified total direct costs, which may be used indefinitely. Costs must be consistently charged as either indirect or direct, and costs may not be double charged. Once chosen, the methodology must be used consistently for all federal awards until such time as a nonfederal entity chooses to negotiate for a new rate, which the nonfederal entity may apply to do at any time.
- As described in lines 1-2, organizations that qualify for the 10% minimum rate include:
- Non-profits with no direct Federal funding and who have never negotiated an indirect cost rate with a Federal agency¹, or
 - State governments, local governments, or tribal entities that receive less than \$35 million in Federal funding and have never negotiated an indirect cost rate with a Federal agency may all elect to use the minimum rate of 10%.
- Line 8:** “Direct costs for CCBHC services” is automatically populated on this line from line 29, column 9, of the Trial Balance tab.
- Line 9:** If Yes is entered on line 7, the minimum rate of 10 percent will appear automatically on this line. Otherwise, the rate will remain blank.
- Line 10:** “Calculated indirect costs allocable to CCBHC services,” which is calculated by multiplying lines 8 and 9 above, is automatically populated on this line. If line 10 is greater than zero, no additional information is needed in this tab.
- Line 11:** Organizations without indirect rate agreements that do not choose or are not qualified for the minimum rate may allocate indirect costs by taking the ratio of direct costs for providing CCBHC covered services to total allowable costs less indirect costs. If the organization chooses this method for allocating direct costs, enter “Yes” and review lines 12 through 14. Otherwise, enter “No” and proceed to question 15.
- Line 12:** If Yes is entered on line 11, the calculated indirect allocation rate is automatically populated on this line.
- The formula for the calculation is described in Table 5: Ratio of Direct Costs.

¹ Additionally, non-profits that receive pass through funds may use a 10% rate in lieu of negotiating an indirect cost rate with the pass through entity.

Table 5: Ratio of Direct Costs

Direct CCBHC Costs	
<hr/> (Total Allowable Costs - Indirect Costs)	
Line 13:	If Yes is entered on line 11, the indirect cost to be allocated is automatically populated on this line from line 49, column 9, of the Trial Balance tab.
Line 14:	“Calculated indirect costs allocable to CCBHC services,” which is calculated by multiplying lines 12 and 13 above, is automatically populated on this line. If line 14 is greater than zero, no additional information is needed in this tab.
Line 15:	If none of lines 1, 7, or 11 are entered as “Yes,” provide a thorough description of the indirect costs allocated to CCBHC services in the Allocation Descriptions tab. This detailed description should include references to line items in the Trial Balance tab that describe the basis as well as the calculation of the indirect cost.
Line 16:	“Total Indirect Costs allocated to CCBHC services,” which is calculated from the total indirect costs allocated to CCBHC services from line 6, 10, 14, or 15, is automatically populated on this line.

9

Allocation Descriptions Tab

Use the Allocation Descriptions tab for describing calculations and methods that support the allocation methodology of direct and indirect costs. Each allocation should be referenced to the applicable adjustment or reclassification on the appropriate tabs. If the trial balance or trial balance crisis contained the adjustments or reclassifications prior to importing into the cost report, note the methodologies and calculations used. This information can be summarized and should contain occupational grouping, allocation statistics, and the allowable adjustments or reclassifications as applicable.

If an allocation is used for direct costs, enter a description of allocations for the following sections as needed. Examples of common allocation methods for classifying costs as direct or indirect for each section are listed below. The examples given are not the only acceptable methods for allocating costs.

- Part 1A: CCBHC Staff Costs
 - Common methods for allocating staff costs include Random Moment Time Studies applied to the total salary for the group. *If a Random Moment Time Study was performed, it should follow a CMS-approved methodology.* Other common allocation methods include percentage of billed time, or percentage of billed amount attributed to services on the state CCBHC scope of services. The allocation method likely creates a reclassification amount that should be described in the Trial Balance Reclassification tab. The CCBHC should offset salary costs by applicable revenues, such as grants received.
- Part 1B: CCBHC Costs Under Agreement
 - Allocations for costs under agreement should be done by the service provided. Where the DCO arrangement supports more than one service, common allocation methods include percentage of chargeable time and percentage of billed amount.
- Part 1C: Other Direct CCBHC Costs
 - Common methods for non-personnel cost allocations include allocations by full-time equivalent (FTE), actual utilization based on time, and allocations by billed charges. .
- Part 2A: Site Costs
 - Facility costs are often charged by department based on square footage or full-time equivalent.
- Part 2B: Administrative Costs
 - Common allocation methods for administrative costs include billed charges, percentage of departmental revenue, and percentage of FTE.
- Part 3A/B Direct Costs for Services Other than CCHBC Services & Non-Reimbursable Costs
 - Common allocation methods include percentage of billed time, percentage of bill amounts, and random moment time studies.

Additional documentation supporting the summarized allocations should be kept on file for review. Documentation should be sufficient to support an audit or desk review and permit the preparation of reports required by general and program-specific terms and conditions. Documentation should permit

the tracing of funds to a level of expenditures adequate to establish that such funds have been used according to the federal statutes, regulations, and terms and conditions of the federal award.²

The allocation of home office adjustments must be described in detail. Home offices usually furnish central management and administrative services, such as centralized accounting, purchasing, personnel services, management direction and control, information technology and other costs. To the extent that the home office furnishes services related to patient care to a provider, the reasonable costs of such services are included in the CCBHC's direct costs. If the home office of the organization does not provide services related to patient care, the home office may be included in the indirect facility costs allocated to CCBHC services.

If completing line 15 of the Indirect Cost Allocations tab, describe the indirect cost allocation method in detail on this tab in the appropriate section. For example, a portion of the facility is directly attributable and exclusively used to provide CCBHC services may be allocated based on square footage. For each expense, describe the method for allocating related costs, such as percentage of total FTE or percentage of square footage. The total of all indirect expenses allocable to CCBHCs using the methods described on this page should support the amount on line 15 of the Indirect Cost Allocations tab.

² 45 CFR §75.302

10

Daily Visits PPS-1 Tab

If using CC PPS-1, use the Daily Visits PPS-1 tab to summarize the visits furnished by your health care staff and by physicians under agreement with you that apply specifically to CCBHC services.

Include days with visits from both Medicaid-covered and non-Medicaid-covered recipients. Consolidate visits for all facilities reported for the CCBHC.

PATIENT DEMOGRAPHICS CONSOLIDATED

This section is for reporting consolidated patient demographics. Visits by one patient to multiple locations on the same day should be counted only once.

Column Descriptions

Column 1: Enter the total number of days with patient visits for CCBHC services during the reporting period.

Line Descriptions

Line 1: Enter the counts of unique patient visit days for patients who receive CCBHC services directly from CCBHC staff.

Line 2: Enter the counts of unique patient visit days for patients who receive CCBHC services from a designated collaborating organization (DCO). If a patient receives services directly from a DCO and from the CCBHC on the same day, the unique patient visit day should be counted only on line 1.

Line 3: Enter the total number of additional anticipated unique patient visit days for patients irrespective of payer receiving CCBHC demonstration services not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.

Line 4: "Total daily visits for patients receiving CCBHC services," which is calculated by adding the amounts on lines 1 through 3 above, is automatically populated on this line.

11

Monthly Visits PPS-2 Tab

If using CC PPS-2, use the Monthly Visits PPS-2 tab to summarize the counts of unique patient visit months for CCBHC services furnished by your health care staff and by physicians under agreement with you. Categorize and count the unique patient month only once either for the standard population or for one of the recipients with certain conditions defined by the state. The count of months should include visits by Medicaid-covered and non-Medicaid-covered recipients.

PATIENT DEMOGRAPHICS CONSOLIDATED

This section is for reporting the consolidated patient demographics. A patient visit to multiple locations in the same month should be counted only once.

Column Descriptions

Selected columns in this tab categorize costs according to whether they are above the monthly outlier threshold and whether they were allocated to certain conditions. Prior to completing the cost reports, the state should have specified the outlier threshold and the conditions.

- Column 1a:** Enter the total number of unique patient visit months for patients in the standard population who do not meet the criteria for having certain conditions.
- Column 1b:** Enter the total number of unique patient visit months for patients without certain conditions whose costs are above the outlier threshold determined by the state. This number of patient visit months in this column is a subset of the number in column 1a.
- Column 2a:** Enter the total number of unique patient visit months for patients with Certain Conditions 1.
- Column 2b:** Enter the total number of unique patient visit months for patients with certain conditions 1 whose costs are above the outlier threshold determined by the state. The unique number of patient visit months in this column is a subset of the amounts included in column 2a.
- Column 3a:** Enter the total number of unique patient visit months for patients with Certain Conditions 2.
- Column 3b:** Enter the total number of unique patient visit months for patients with Certain Conditions 2 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 3a.
- Column 4a:** Enter the total number of unique patient visit months for patients with Certain Conditions 3.
- Column 4b:** Enter the total number of unique patient visit months for patients with Certain Conditions 3 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 4a.

- Column 5a:** Enter the total number of unique patient visit months for patients with Certain Conditions 4.
- Column 5b:** Enter the total number of unique patient visit months for patients with Certain Conditions 4 whose costs exceeded the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 5a.
- Column 6a:** Enter the total number of unique patient visit months for patients with Certain Conditions 5.
- Column 6b:** Enter the total number of unique patient visit months for patients with certain conditions 5 whose costs are above the outlier threshold determined by the state. The unique number of patient visit months in this column is a subset of the amounts included in column 6a.
- Total:** The total column, which is calculated by adding the total number of unique patient visit months from the “a” columns (i.e., 1a, 2a, 3a, etc.), is automatically populated on this line. The number of visits in the “b” columns (i.e., 1b, 2b, 3b, etc.) is not included in the sum in the total column.

Line Descriptions

- Line 1:** Provide details regarding the certain conditions populations to help distinguish the groups.
- Line 2:** Enter the counts of unique patient visit months for patients who receive CCBHC services directly from staff.
- Line 3:** Enter the counts of unique patient visit months for patients who receive CCBHC services from a designated collaborating organization (DCO). If a patient receives services directly from a DCO and from the CCBHC on the same day, count the unique patient visit month only on line 2.
- Line 4:** Enter the total number of additional anticipated unique patient visit months for patients irrespective of payer receiving CCBHC demonstration services by population not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.
- Line 5:** “Total months patients received CCBHC services,” which is calculated by adding lines 2 through 4 above, is automatically populated on this line.

12

Daily Visits CC PPS-3 Tab

If using CC PPS-3, use the Daily Visits PPS-3 tab to summarize the visits furnished by your health care staff and by physicians under agreement with you that apply specifically to CCBHC services.

Include days with visits from both Medicaid-covered and non-Medicaid-covered recipients. Consolidate visits for all facilities reported for the CCBHC. All visits need to fit into the four column categories provided (Mobile Crisis 9813, Mobile Crisis Non-9813, Crisis Stabilizations, and Non-Crisis).

If the CCBHC is electing to use the PPS-3 method Non-Crisis services must be entered and at least one SCS service.

PATIENT DEMOGRAPHICS CONSOLIDATED

This section is for reporting consolidated patient demographics. Visits by one patient to multiple locations on the same day should be counted only once.

Column Descriptions

Columns 1-4:- Enter the total number of days with patient visits for CCBHC services during the reporting period for each respective service.

Line Descriptions

- Line 1:** Enter the counts of unique patient visit days for patients who receive CCBHC services directly from CCBHC staff.
- Line 2:** Enter the counts of unique patient visit days for patients who receive CCBHC services from a designated collaborating organization (DCO). If a patient receives services directly from a DCO and from the CCBHC on the same day, the unique patient visit day should be counted only on line 1.
- Line 3:** Enter the total number of additional anticipated unique patient visit days for patients irrespective of payer receiving CCBHC demonstration services not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.
- Line 4:** "Total daily visits for patients receiving CCBHC services," which is calculated by adding the amounts on lines 1 through 3 above, is automatically populated on this line.

13

Monthly Visits CC PPS-4 Tab

If using CC PPS-4, use the Monthly Visits PPS-4 tab to summarize the counts of unique patient visit months for CCBHC services furnished by your health care staff and by physicians under agreement with you. Categorize and count the unique patient month only once either for the standard population or for one of the recipients with certain conditions defined by the state. The count of months should include visits by Medicaid-covered and non-Medicaid-covered recipients.

If the CCBHC is electing to use the PPS-4 method Non-Crisis services must be entered and at least one SCS service.

PATIENT DEMOGRAPHICS CONSOLIDATED

This section is for reporting the consolidated patient demographics. A patient visit to multiple locations in the same month should be counted only once.

Column Descriptions

Selected columns in this tab categorize costs according to whether they are above the monthly outlier threshold and whether they were allocated to certain conditions. Prior to completing the cost reports, the state should have specified the outlier threshold and the conditions. Columns 1-6 relate to Non-Crisis services and their respective conditions. Column 7-9 relate to special crisis services.

- Column 1a:** Enter the total number of unique patient visit months for patients in the standard population who do not meet the criteria for having certain conditions.
- Column 1b:** Enter the total number of unique patient visit months for patients without certain conditions whose costs are above the outlier threshold determined by the state. This number of patient visit months in this column is a subset of the number in column 1a.
- Column 2a:** Enter the total number of unique patient visit months for patients with Certain Conditions 1.
- Column 2b:** Enter the total number of unique patient visit months for patients with certain conditions 1 whose costs are above the outlier threshold determined by the state. The unique number of patient visit months in this column is a subset of the amounts included in column 2a.
- Column 3a:** Enter the total number of unique patient visit months for patients with Certain Conditions 2.
- Column 3b:** Enter the total number of unique patient visit months for patients with Certain Conditions 2 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 3a.
- Column 4a:** Enter the total number of unique patient visit months for patients with Certain Conditions 3.

- Column 4b:** Enter the total number of unique patient visit months for patients with Certain Conditions 3 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 4a.
- Column 5a:** Enter the total number of unique patient visit months for patients with Certain Conditions 4.
- Column 5b:** Enter the total number of unique patient visit months for patients with Certain Conditions 4 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 5a.
- Column 6a:** Enter the total number of unique patient visit months for patients with Certain Conditions 5.
- Column 6b:** Enter the total number of unique patient visit months for patients with Certain Conditions 5 whose costs are above the outlier threshold determined by the state. The number of unique patient visit months in this column is a subset of the amounts included in column 6a.
- Column 7** Enter the total number of unique patient visit months for patients utilizing Mobile Crisis 9813
- Column 8** Enter the total number of unique patient visit months for patients utilizing Mobile Crisis Non-9813.
- Column 9** Enter the total number of unique patient visit months for patients utilizing Crisis Stabilization.
- Total:** The total column, which is calculated by adding the total number of unique patient visit months from the “a” columns (i.e., 1a, 2a, 3a, etc.) and the SCS columns 7-9, is automatically populated. The number of visits in the “b” columns (i.e., 1b, 2b, 3b, etc.) is not included in the sum in the total column.

Line Descriptions

- Line 1:** Provide details regarding the certain conditions populations to help distinguish the groups.
- Line 2:** Enter the counts of unique patient visit months for patients who receive CCBHC services directly from staff.
- Line 3:** Enter the counts of unique patient visit months for patients who receive CCBHC services from a designated collaborating organization (DCO). If a patient receives services directly from a DCO and from the CCBHC on the same day, count the unique patient visit month only on line 2.
- Line 4:** Enter the total number of additional anticipated unique patient visit months for patients irrespective of payer receiving CCBHC demonstration services by population not included above. Anticipated visits are allowed for demonstration year 1 only. Demonstration year 2 requires actual data.
- Line 5:** “Total months patients received CCBHC services,” which is calculated by adding lines 2 through 4 above, is automatically populated on this line.

14

Services Provided Tab

Use the Services Provided tab to provide information about the number of full-time equivalents (FTEs) and the number of services provided for CCBHC services for each type of practitioner. The number of services provided should reflect the actual number of services provided from all encounters. This number represents the total quantity (units) of services provided, as opposed to the number of days that each patient received services as described in section 10/12 or the number of months that each patient received services as described in Section 11/13.

PART 1 – SERVICES PROVIDED (Consolidated)

Column Descriptions

- Column 1:** Enter the number of FTEs for each staff position; these numbers should correspond to the expenses listed in Trial Balance tab.
- Column 2:** Enter the total number of services provided for CCBHC services actually furnished to all patients for each staff position.
- Column 3:** “Direct cost,” is automatically populated on this line from the Trial Balance tab, column 9.
- Column 4:** “Average cost per service by position,” which is calculated by taking the net cost from column 3, and dividing it by the number of services provided as listed in column 2, is automatically populated on this line.

Line Descriptions

PART 1A: CCBHC STAFF SERVICES

- Lines 1–16:** Enter the number of FTEs and services provided by the health care staff on the appropriate line by type of staff in columns 1 and 2, as described above.
- Line 17:** Enter a subtotal of the number of FTEs and services for all other appropriate staff not listed on lines 1–16, and specify details in the Comments tab.
- Line 18:** “Subtotal staff services,” which is calculated by adding the amounts on lines 1–17 above, is automatically populated on this line.

PART 1B: CCBHC SERVICES UNDER AGREEMENT

- Line 19:** Enter the CCBHC services provided from the DCO.
- Line 20:** Enter a subtotal of all other CCBHC services, and specify details in the Comments tab.
- Line 21:** “Subtotal of services under agreement” is automatically populated from the amounts on lines 19 through 20 above.
- Line 22:** “Total services” is automatically populated by adding the amounts on lines 18 and 21 above.

Line 23: Line 23 automatically populates the number of sites included in the cost report from question 18 in the Provider Information tab. For each site, copy and complete Part 2 below.

PART 2 – SERVICES PROVIDED BY SITE

Column Descriptions

Column 1: Enter the number of FTEs for each expense category position listed, corresponding to the expenses listed in Trial Balance tab.

Column 2: Enter the total number of services provided for CCBHC services furnished to all patients for each staff.

Line Descriptions

PART 2A: CCBHC STAFF SERVICES BY SITE

Lines 1–16: Enter the number of FTEs and services provided by the health care staff on the appropriate line by type of staff in columns 1 and 2, as described above.

Line 17: Enter a subtotal of the number of FTEs and services for all other appropriate staff not listed on lines 1–16, and specify details in the Comments tab.

Line 18: “Subtotal staff services,” which is calculated by adding the amounts on lines 1–17 above, is automatically populated on this line.

PART 2B: CCBHC SERVICES UNDER AGREEMENT BY SITE

Line 19: Enter the units of CCBHC services provided from the DCO.

Line 20: Enter a subtotal of all other services, and specify details in the Comments tab.

Line 21: “Subtotal of services under agreement” is automatically populated from the amounts on lines 19 through 20 above.

Line 22: “Total services” is automatically populated by adding the amounts on lines 18 and 21 above.

Complete Part 2 for each satellite site. When more than one satellite site exists, create a new tab within the workbook labeled “Services Provided Cont.”. For each satellite site copy and paste all of Part 2 into the new tab and complete the form.

15

Comments Tab

Use this worksheet to explain any considerations (such as cost anomalies or explanations for deviations from accrual accounting principles) to inform further the justification of expenses used to determine the payment rate.

16

CC PPS-1 Rate Tab

Use the CC PPS-1 Rate tab to calculate the daily rate to be finalized by the state. The daily rate is based on the expected costs of all demonstration services irrespective of payer.

PART 1 – DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC

If the suggested order of completion described in Table 2: Recommended Order is followed, the information on lines 1–3 will be auto populated from data entered from other areas of the cost report and does not need to be re-entered here.

- Line 1:** “Total direct CCBHC costs” is automatically populated on this line from the Trial Balance tab, line 29, column 9.
- Line 2:** “Indirect costs allocated to CCBHC services” is automatically populated on this line from the Indirect Cost Allocation tab, line 16.
- Line 3:** “Total allowable CCBHC costs,” which is calculated by adding lines 1 and 2 above, is automatically populated on this line.

PART 2 – DETERMINATION OF CC PPS-1 RATE

- Line 4:** “Total allowable CCBHC costs” is automatically populated on this line from line 3 above.
- Line 5:** “Total CCBHC visits” is automatically populated on this line from the Daily Visits CC PPS-1 tab, line 4, column 1. The total CCBHC visits number should include visits from all patients for CCBHC services, not just Medicaid visits.
- Line 6:** “Unadjusted PPS rate” (the total allowable cost per visit during the reporting period), which is calculated by dividing line 4 by line 5 above, is automatically populated on this line.
- Line 7:** Enter the applicable Medicare Economic Index (MEI). The MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period.
- Line 8:** “CC PPS-1 rate” for CCBHC services, which is calculated by adjusting the amount on line 6 by the MEI on line 7 above, is automatically populated on this line.

17

CC PPS-2 Rate Tab

Use the CC PPS-2 Rate tab to calculate a preliminary PPS rate based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer. The calculation of the PPS rate is preliminary and will be finalized by the state in accordance with the state's policy concerning outlier payments.

Costs must be allocated to the standard and special populations identified in Section 11 (Monthly Visits CC PPS-2 tab) of this document. One acceptable method of allocating cost by population is multiplying a cost-to-charge ratio by charges incurred for each population. The cost-to-charge ratio represents total costs, including anticipated costs for all users regardless of payer divided by all charges for all users regardless of payer. Each individual charge is multiplied by the ratio to estimate the cost of performing each service. Those costs should be categorized by patient and evaluated to determine if costs exceed the outlier threshold.

The use of the cost-to-charge ratio requires uniform charges for comparable demonstration services. The state may require an attestation that the CCBHC is using a uniform charges each time the service is provided during the month. As a condition of participation in the demonstration program, CCBHCs must collect and report encounter, clinical outcome, and quality improvement data. CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures. The CCBHC should be recording this information per CCBHC criteria 5.a.4.

PART 1 – COST-TO-CHARGE RATIO ALLOCATION

Column Descriptions

The columns in this tab categorize costs using the cost-to-charge ratio according to (1) whether they are at, below, or above the monthly outlier threshold and (2) whether they were allocated to certain conditions or to the standard population. Prior to completing the cost reports, the state should have specified the outlier threshold and the conditions. Cost-to-charge ratios are applied to the covered charges for each case to determine whether the costs of the case exceed the outlier threshold. Each state will determine the cost thresholds for outlier payment, which will affect reporting of charge data.

- Column 1a:** Enter the total costs and charges at or below the monthly outlier threshold for patients without certain conditions.
- Column 1b:** Enter the total cost and charges above the monthly outlier threshold for patients without certain conditions.
- Column 2a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 1.
- Column 2b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 1.

- Column 3a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 2.
- Column 3b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 2.
- Column 4a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 3.
- Column 4b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 3.
- Column 5a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 4.
- Column 5b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 4.
- Column 6a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 5.
- Column 6b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 5.

Line 1: Enter the covered charges for CCBHC services under each population group in columns 1a–10b, as described above. The total column at the far right of this table sums the “Total Population Charges.”

Line 2: ***For demonstration year 1 (DY1) only***, enter the additional anticipated covered charges for CCBHC services under each population group in columns 1a–10b, as described above. These should only be charges not captured in line 1. The total column at the far right of this table sums the “Total Population Charges.”

Line 3: Line 3 automatically populates with the sum of line 1 and line 2.

Total Column: “Total Population Charges,” which is calculated by adding the amounts in all columns from 1a to 6b, is automatically populated in this cell.

Line Descriptions

Line 4: Line 4 automatically populates the total column with the total direct costs for CCBHC services from the Trial Balance tab, column 9, line 29.

Line 5: Line 5 automatically populates the total column with the total indirect costs for CCBHC services from the Indirect Cost Allocation tab, line 16.

Line 6: Line 6 automatically populates the total column with the sum from line 4 and line 5.

Line 7: Line 7 automatically populates the total column with the cost-to-charge ratio determined by dividing line 6 by line 3.

Line 8: Line 8 automatically calculates costs for each population based on the cost-to-charge ratio. Charges from line 3 are multiplied by the cost-to-charge ratio in the total column of line 7.

A validation check appears below Part I to verify that total costs tie to the total direct and indirect costs applicable to CCBHC services (line 6).

PART 2 – DETERMINATION OF CC PPS-2 RATE

- Line 9:** “Total allowable CCBHC costs” is automatically populated on this line from the allowable CCBHC costs on line 8 above.
- Line 10:** “Total months patients received CCBHC services” is automatically populated on this line from the total visits in the Monthly Visits CC PPS-2 tab, line 5. Column “a” reflects the total count of visits, and column “b” reflects the total count for cases in which costs are above the outlier threshold determined by the state.
- Line 11:** “Total allowable cost per visit,” which is calculated by dividing line 9 by line 10 above to come up with the total allowable cost per visit during the reporting period, is automatically populated on this line.
- Line 12:** Enter the applicable Medicare Economic Index (MEI). The MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period.
- Line 13:** “CC PPS-2 rate,” which is calculated by adjusting line 11 by the factor from the column total (on the far right) on line 12 above to determine the CC PPS-2 rate payable for each population type, is automatically populated on this line.
- Line 14:** “Outlier pool,” which is calculated by adding the total outlier pool amounts from line 9, is automatically populated on this line.

For more information on how to calculate the outlier payments, see the CCBHC Guidance

Document available at <http://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf>.

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CC PPS-3 Rate Tab

Use the CC PPS-3 Rate tab to calculate the daily rate to be finalized by the state. The daily rate is based on the expected costs of all demonstration services irrespective of payer. This Rate Tab calculates separate Mobile Crisis 9813, Mobile Crisis Non-9813, Crisis Stabilization, and Non-Crisis PPS Rates.

If the CCBHC is electing to use the PPS-3 method Non-Crisis services must be entered and at least one SCS service.

PART 1 – DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC

If the suggested order of completion described in Table 2: Recommended Order is followed, the information on lines 1–3 will be auto populated from data entered from other areas of the cost report and does not need to be re-entered here.

- Line 1:** “Total direct CCBHC costs” is automatically populated on this line from the Trial Balance Crisis tab, line 29, columns 1-4.
- Line 2:** “Indirect costs allocated to CCBHC services” is automatically populated on this line from the Indirect Cost Allocation tab, line 16 multiplying by their percentage of total direct CCBHC cost for each respective service found in the Trial Balance Crisis tab, line 30, columns 1-4.
- Line 3:** “Total allowable CCBHC costs,” which is calculated by adding lines 1 and 2 above, is automatically populated on this line.

PART 2 – DETERMINATION OF CC PPS-3 RATE

- Line 4:** “Total allowable CCBHC costs” is automatically populated on this line from line 3 above.
- Line 5:** “Total CCBHC visits” is automatically populated on this line from the Daily Visits CC PPS-3 tab, line 4, columns 1-4. The total CCBHC visits number should include visits from all patients for CCBHC services, not just Medicaid visits.
- Line 6:** “Unadjusted PPS rate” (the total allowable cost per visit during the reporting period), which is calculated by dividing line 4 by line 5 above, is automatically populated on this line.
- Line 7:** Enter the applicable Medicare Economic Index (MEI). The MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period.
- Line 8:** “CC PPS-3 rate” for CCBHC services, which is calculated by adjusting the amount on line 6 by the MEI on line 7 above, is automatically populated on this line.

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CC PPS-4 Rate Tab

Use the CC PPS-4 Rate tab to calculate a preliminary PPS rate based on costs for all CCBHC demonstration services provided to all CCBHC clinic users irrespective of payer. The calculation of the PPS rate is preliminary and will be finalized by the state in accordance with the state's policy concerning outlier payments.

Costs must be allocated to the standard and special populations as well as crisis services identified in Section 13 (Monthly Visits CC PPS-4 tab) of this document. One acceptable method of allocating cost by population is multiplying a cost-to-charge ratio by charges incurred for each population. The cost-to-charge ratio represents total costs, including anticipated costs for all users regardless of payer divided by all charges for all users regardless of payer. Each individual charge is multiplied by the ratio to estimate the cost of performing each service. Those costs should be categorized by patient and evaluated to determine if costs exceed the outlier threshold.

The use of the cost-to-charge ratio requires uniform charges for comparable demonstration services. The state may require an attestation that the CCBHC is using a uniform charges each time the service is provided during the month. As a condition of participation in the demonstration program, CCBHCs must collect and report encounter, clinical outcome, and quality improvement data. CCBHC consumer claim or encounter data must be linkable to the consumer's pharmacy claims or utilization information, inpatient and outpatient claims, and any other claims or encounter data necessary to report the measures. The CCBHC should be recording this information per CCBHC criteria 5.a.4.

Please note special crisis services do not utilize cost-to charge ratio allocation for their rate methodology so actual charges will equal their respective trial balance total direct costs plus their calculated indirect costs

If the CCBHC is electing to use the PPS-3 method Non-Crisis services must be entered and at least one SCS service.

PART 1 – COST-TO-CHARGE RATIO ALLOCATION

Column Descriptions

The columns in this tab categorize costs using the cost-to-charge ratio according to (1) whether they are at, below, or above the monthly outlier threshold and (2) whether they were allocated to certain conditions or to the standard population. Prior to completing the cost reports, the state should have specified the outlier threshold and the conditions. Cost-to-charge ratios are applied to the covered charges for each case to determine whether the costs of the case exceed the outlier threshold. Each state will determine the cost thresholds for outlier payment, which will affect reporting of charge data.

Column 1a: Enter the total costs and charges at or below the monthly outlier threshold for patients without certain conditions.

Column 1b: Enter the total cost and charges above the monthly outlier threshold for patients without certain conditions.

- Column 2a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 1.
- Column 2b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 1.
- Column 3a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 2.
- Column 3b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 2.
- Column 4a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 3.
- Column 4b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 3.
- Column 5a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 4.
- Column 5b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 4.
- Column 6a:** Enter the total cost and charges at or below the monthly outlier threshold for patients with Certain Conditions 5.
- Column 6b:** Enter the total cost and charges above the monthly outlier threshold for patients with Certain Conditions 5.
- Total Column (Non-SCS)** “Total Population Charges,” which is calculated by adding the amounts in all columns from 1a to 6b, is automatically populated in this cell.
- Column 7:** Enter the charges for Mobile Crisis 9813.
- Column 8:** Enter the charges for Mobile Crisis Non-9813.
- Column 9:** Enter the total cost and charges for Crisis Stabilization.
- Total Column:** “Total Population Charges,” which is calculated by adding the amounts in all columns from 1a to 9, is automatically populated in this cell.

Line Descriptions

A validation check appears below Part I to verify that total costs tie to the total direct and indirect costs applicable to CCBHC services (line 6).

The example below demonstrates how the Non-Crisis Standard Population and Certain Conditions use the cost to charge method of allocating CCBHC.

- Line 1:** Enter the covered charges for CCBHC services under each population and service group in columns 1a–9, as described above. The total column at the far right of this table sums the “Total Population Charges.”
- Line 2:** ***For demonstration year 1 (DY1) only***, enter the additional anticipated covered charges for CCBHC services under each population group in columns 1a–9, as described above. These should only be charges not captured in line 1. The total column at the far right of this table sums the “Total Population Charges.”
- Line 3:** Line 3 automatically populates with the sum of line 1 and line 2.

- Line 4:** Line 4 automatically populates the total column with the total direct costs for CCBHC services from the Trial Balance Crisis tab, column 9, line 29.
- Line 5:** Line 5 automatically populates the variance between the total direct costs on the Trial Balance Crisis tab and actual charges. The result should be \$0 indicating no variance.
- Line 6:** Line 6 automatically populates the total column with the total indirect costs for CCBHC services from the Indirect Cost Allocation tab, line 16 multiplying by their % of total direct CCBHC cost for each respective service.
- Line 7:** Line 7 automatically populates the total column with the sum from line 4 and line 6.
- Line 8:** Line 8 automatically populates the total column with the cost-to-charge ratio determined by dividing line 7 by line 3.
- Line 9:** Line 9 automatically calculates costs for each population based on the cost-to charge ratio. Charges from line 3 are multiplied by the cost-to-charge ratio in the total column of line 8.

PART 1a - COST-TO-CHARGE RATIO ALL											
Population	Condition 3		Condition 4		Condition 5			All	All	All	
Description	Certain Conditions 3 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 4a	Certain Conditions 3 Charges and Costs for CCBHC Services: Above the Outlier Threshold 4b	Certain Conditions 4 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 5a	Certain Conditions 4 Charges and Costs for CCBHC Services: Above the Outlier Threshold 5b	Certain Conditions 5 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 6a	Certain Conditions 5 Charges and Costs for CCBHC Services: Above the Outlier Threshold 6b	Total Population Charges and Costs (Sum of non-SCS Columns)	Mobile Crisis 9813 7	Mobile Crisis Non-9813 8	Crisis Stabilization 9	Total Population Charges and Costs (Sum of all Columns)
1 Actual charges	\$1,000,000.00	\$500,000.00	\$1,000,000.00	\$500,000.00	\$1,000,000.00	\$500,000.00	\$9,000,000.00	\$250,000.00	\$375,000.00	\$500,000.00	\$10,125,000.00
2 Anticipated additional charges (DY1 only)	\$1,000.00	\$100.00	\$1,000.00	\$100.00	\$1,000.00	\$100.00	\$6,600.00	\$0.00			\$6,600.00
3 Total charges (sum of lines 1-2)	\$1,001,000.00	\$500,100.00	\$1,001,000.00	\$500,100.00	\$1,001,000.00	\$500,100.00	\$9,006,600.00	\$250,000.00	\$375,000.00	\$500,000.00	\$10,131,600.00
4 Total direct costs (Trial Balance Crisis, column 9, line 29)							\$10,308,908.57	\$250,000.00	\$375,000.00	\$500,000.00	\$11,433,908.57
5 Variance (difference of lines 3-4)							-\$1,302,308.57	\$0.00	\$0.00	\$0.00	-\$1,302,308.57
6 Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16)							\$1,123,352.14	\$27,242.27	\$40,863.40	\$54,484.53	\$1,245,942.34
7 Total allowable costs for CCBHC services (sum of lines 4 & 6)							\$11,432,260.72	\$277,242.27	\$415,863.40	\$554,484.53	\$12,679,850.92
8 Cost-to-charge ratio services (line 7 divided by line 3)							127%				
9 Total cost of CCBHC services (line 3 times line 8)	\$1,270,589.68	\$634,787.11	\$1,270,589.68	\$634,787.11	\$1,270,589.68	\$634,787.11	\$11,432,260.72	\$277,242.27	\$415,863.40	\$554,484.53	\$12,679,850.92

PART 2 – DETERMINATION OF CC PPS-4 RATE

- Line 10:** “Total allowable CCBHC costs” is automatically populated on this line from the allowable CCBHC costs on line 8 above.
- Line 11:** “Total months patients received CCBHC services” is automatically populated on this line from the total visits in the Monthly Visits tab, line 5. Column “a” reflects the total count of visits, and column “b” reflects the total count for cases in which costs are above the outlier threshold determined by the state.
- Line 12:** “Total allowable cost per visit,” which is calculated by dividing line 9 by line 10 above to come up with the total allowable cost per visit during the reporting period, is automatically populated on this line.
- Line 13:** Enter the applicable Medicare Economic Index (MEI). The MEI should trend the costs from the midpoint of the cost period to the midpoint of the rate period.

Line 14: “CC PPS-4 rate,” which is calculated by adjusting line 11 by the factor from the column total (on the far right) on line 12 above to determine the CC PPS-4 rate payable for each population type, is automatically populated on this line.

Line 15: “Outlier pool,” which is calculated by adding the total outlier pool amounts from line 9, is automatically populated on this line.

The example below demonstrates how the Non-Crisis services and Crisis services rates are calculated in the final step.

PART 1b - DETERMINATION OF CC PPS-4											
	Condition 3		Condition 4		Condition 5			All	All	All	
Description	Certain Conditions 3 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 4a	Certain Conditions 3 Charges and Costs for CCBHC Services: Above the Outlier Threshold 4b	Certain Conditions 4 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 5a	Certain Conditions 4 Charges and Costs for CCBHC Services: Above the Outlier Threshold 5b	Certain Conditions 5 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 6a	Certain Conditions 5 Charges and Costs for CCBHC Services: Above the Outlier Threshold 6b	Total Population Charges and Costs (Sum of non-SCS Columns) Total	Mobile Crisis 9813 7	Mobile Crisis Non-9813 8	Crisis Stabilization 9	Total Population Costs (Sum of all Columns) Total
10 Total allowable CCBHC costs (line 9)	\$1,270,589.68	\$634,787.11	\$1,270,589.68	\$634,787.11	\$1,270,589.68	\$634,787.11	\$11,432,260.72	\$277,242.27	\$415,863.40	\$554,484.53	\$12,679,850.92
11 Total months patients received CCBHC services (Monthly Visits, line 5)*	1600		1600		1600		9600	450	450	450	20550
12 Total allowable cost per visit (line 10 divided by line 11)	\$794.12		\$794.12		\$794.12		\$1,190.86	\$616.09	\$924.14	\$1,232.19	\$617.02
13 Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period							7.982%	7.982%	7.982%	7.982%	7.982%
14 CC PPS-2 rate (line 12 adjusted by factor from column Total, line 13)	\$857.51		\$857.51		\$857.51		\$1,285.91	\$665.27	\$997.91	\$1,330.54	\$666.28
15 Outlier pool (line 10)		\$634,787.11		\$634,787.11		\$634,787.11	\$3,808,722.66				\$7,617,445.32
* Column "a" reflects the count for All visits.											
OMB #0398-1148 CMS-10398 (#43)											
End of Worksheet											

For more information on how to calculate the outlier payments, see the CCBHC Guidance

Document available at <http://www.samhsa.gov/sites/default/files/grants/pdf/sm-16-001.pdf>.

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Certification Tab

Prepare and sign the certification statement after the worksheets have been completed. The individual signing this statement must be an officer or other authorized administrator. Cost reports should include certification from the chief executive officer (CEO), the chief financial officer (CFO), or an authorized delegate who reports to the CEO or CFO.