This document is a Draft and contains suggestions from DHR for providers who may be operating multiple, separate programs or facilities that include child-caring and behavioral healthcare programs.

It may be revised in the future based on feedback and as new information is received from the Department of Community Health (DCH) and/or Centers for Medicare and Medicaid Services (CMS).

Please ensure that you are using the most recent copy by checking the Provider Information section on the Division of MHDDAD website at http://mhddad.dhr.georgia.gov/portal/site/DHR-MHDDAD/

Establishing and Maintaining Separation Between Multiple Programs and Facilities:

Suggestions for Organizations Operating Child-Caring Institutions (CCIs)/Child-Placing Agencies (CPAs) and Psychiatric Residential Treatment Facilities (PRTFs) and/or Mental Health Outpatient Services as a Medicaid Rehabilitation Option (MRO) Provider

DRAFT DRAFT DRAFT

May 29, 2007

Georgia Department of Human Resources
Division of Mental Health, Developmental Disabilities, and Addictive Diseases
Division of Family and Children's Services
Office of Regulatory Services

Table of Contents

Introduction 3
Physical Separation 5
Documentation of Physical Separation 5
Entrances and Signage 5
Building Space 5
Common Areas 6
Financial Separation 7
Administrative Separation 8
Staffing Lists and Schedules 8
Staff Awareness 8
Records Management 8
Programmatic Separation 10
Licensure and Certification 10
Distinct Levels of Care 10
Distinct Types of Care 10
Literature about the Facility/Program 11
Service to Community Residents – Prohibition against Self-Referral 11
Appendices 12

Introduction

In the absence of official guidance at this time from CMS, these suggestions for establishing and maintaining separateness between programs and facilities are offered by the Department of Human Resources to assist organizations that operate more than one type of facility (CCI/CPA, PRTF, and MRO outpatient services), especially when those are located on the same property. By offering these suggestions, we make no expressed or implied representation that CMS would find sufficient distinctness between programs even if an organization followed all these suggestions. Providers are encouraged to read the documents referenced here along with any others they find pertinent and take any and all other steps they determine are important and necessary to operate their programs and facilities in a manner that provides for clear physical and fiscal distinction.

When organizations operate more than one type of program or facility such as a child caring institution (CCI)/child-placing agency (CPA) and a psychiatric residential treatment facility (PRTF) and/or an outpatient mental health service under the Medicaid Rehabilitation Option (MRO provider), care must be taken to preserve the distinct nature and separateness of the programs and facilities. While MRO clinics and PRTFs provide clinical behavioral healthcare services, CCIs/CPAs provide child care services. If an organization operates multiple programs, t is important to separate types of programs (CCI/CPA from PRTF and/or MRO) and separate the two levels of care (PRTF from MRO).

Medicaid recipients have freedom of choice of providers. Therefore, organizations that make referrals for individuals in their care for other types of services (e.g. referral for aftercare for a child being discharged from a PRTF; assisting a CCI/CPA resident in accessing behavioral healthcare; referring an MRO client for PRTF services), may not self-refer individuals to services provided by their parent organization. They must offer a full range of choice of providers which may include their parent organization's services. The provision of this choice must be documented in the individual's clinical record or, in the case of a resident of a CCI/CPA, in the resident's file maintained by the CCI/CPA. We suggest that each agency develop a standard form that can be signed by the individual, parent, or guardian to confirm that a choice of providers was offered. In addition, providers who have an MRO outpatient clinic must provide those services to the public and not just to individuals who are receiving other types of care from the parent organization. The clinic must be accessible to the public (i.e. no locked gates encompassing the property containing the MRO clinic) and providers should be prepared at all times to demonstrate to state and federal officials how the provision of their services is in keeping with this requirement.

In searching for information that might assist and inform providers, we searched a variety of sources that we believed might offer insight into how CMS could evaluate programs for separateness. One source was Office of the Inspector General audits of

distinct-part nursing facilities in which the two general criteria that are used to define a distinct part are that the nursing facility must be "physically distinguishable from the hospital and fiscally separate for cost reporting purposes"[1]

Additional sources of guidance that we thought could generalize to situations in which the distinctness and separateness of programs are important are described in CMS' State Operations Manual sections describing distinct part skilled and intermediate care nursing facilities within larger institutions, distinct part psychiatric hospitals, guidelines on initial certification "kits", and the importance of the separateness of a Home Health Agency as a part of a larger organization[2]. Staff from the Office of Regulatory Services also provided guidance from their experiences in the past in Georgia in which CMS permitted distinct part separation in other federally certified programs.

Additionally, in 1992, Illinois approached and received permission from the Region V CMS office (then HCFA) regarding certification of two programs of 16 beds or less operating in the same building but offering different levels of care as distinct programs. Therefore, these two programs, with separate cost centers, staff, operating policies and procedures, physical location, and levels of care would not be combined and considered to be an Institution for Mental Diseases (IMD). While CMS Regional Offices may have differing opinions from each other and from their Central Office and may change their opinions at any time, we believed that this may give some indication of how program separation could be evaluated (See Appendix A).

---

[1] Review of Additional Reimbursement for Distinct-Part Nursing Facilities of Public Hospitals In California, Department of Health and Human Services, Office of the Inspector General, December 2006, A-09-05-00050.
[2] Centers for Medicare and Medicaid Services, State Operations Manual, Sections 2762B, 2048, 2003B, 2183can be accessed by searching for "State Operations Manual" at http://www.cms.hhs.gov

Physical Separation

If more than one type of program or facility is operated on the same piece of property, organizations should take steps to ensure that the programs or facilities can be easily identified as separate entities to those entering the property. Areas that we encourage you to consider include:

Documentation of Physical Separation

The areas of the property occupied by the various programs should be clearly marked on campus maps and when buildings are shared, documentation of the parts of buildings occupied by different programs/facilities on floor plans should be clear and are readily available to surveyors or auditors.

Entrances and Signage

When sharing a common property (i.e. same piece of land), the most ideal situation would be to have separate entrances, but when this is not feasible, the organization should use signage which clearly identifies and directs those entering the property or campus to the different facilities. Buildings should be clearly marked with signs that identify the programs or facilities that are located within them. For programs that must be open to the general public (e.g. MRO outpatient clinic), there must not be physical barriers which prevent access or which would signal to those seeking services that the services would not be available to the general public (e.g. a locked gate to the property).

Building Space

Distinct buildings for each program or facility are best for maintaining separateness between programs and facilities. If building space is shared, physical separation of the programs/facilities must be managed within the structure. Again, dividing the building space between programs in a manner that provides for clear and distinct separation of the programs and costs is the goal.

Programs that share a building must be clearly separated by floors, wings, or other building sections. Living areas must not be shared and beds from different programs should not be intermixed pr commingled within the same building section. “Swing” beds or units that are variously used by one program or another depending on census are not acceptable. For example, there cannot be beds that are sometimes utilized by a CCI/CPA and sometimes used by a PRTF.

When a building is occupied by more than one program or facility, utilization of a separate building entrance for each program is preferable. When this is not possible,

separate entrances to each program from a common building lobby could be used. Again, signage within the building should clearly identify the specific program or facility areas. Separate reception areas and/or waiting rooms, if needed, are located within the program-specific areas of the building and individuals receiving services from one program would not have to pass through the area of another program to access the program from which they are receiving services. For example, you cannot access the PRTF through the MRO clinic.

Common Areas

Recreational Areas: If a PRTF and a CCI/CPA are operated on the same property, each program should have separate recreational space for its residents. If there are also common recreational spaces used by both programs (i.e. gyms or other indoor or outdoor sporting and recreation areas), the use of these common areas should be scheduled by the different programs or facilities for separate use and the individuals receiving services from distinct programs should not use the facilities at the same time.

Dining Areas: If a PRTF and a CCI/CPA are operated on the same property, each program should have separate dining space for its residents. If common dining room areas are used by different programs/facilities, they should be used at separately scheduled times and the individuals receiving services from distinct programs/facilities should not use the same dining area at the same time.

Treatment Areas: When an organization is providing both PRTF and MRO services on the same campus or facility, separate areas must be used for treatment.

Financial Separation

Financials are to be program based, with separate budget and reporting structures. Any administrative staff performing cross-program functions must maintain detailed daily time logs capturing the amount of time spent on working within each individual program. Allocation of any expense must follow Generally Accepted Accounting Principles as outlined by the Financial Accounting Standards Board. (Refer to the enclosed Cost Report Training documentation—Appendices B, C & D), as covered during the training sessions held in February 2007.

Administrative Separation

Staffing Lists and Schedules

The cleanest separation would be to not have the same individuals employed in the different programs and it would seem to be a rare situation in which an individual would work for both the CCI/CPA program and one of the mental health programs (MRO or PRTF) since these are not even the same types of programs (child care vs. behavioral healthcare).

Each program/facility should maintain a separate list of staff who work for the program. Staff work schedules should be separate for each program and should clearly indicate only that staff that work for that distinct program. Staff absolutely may not be shared between programs at the same time (i.e. staff must be working for only one program/facility at a time) and we strongly encourage employment of separate staff for each program/facility. Staff assignments, time sheets and/or other documentation supporting separate assignment of staff to the programs/facilities should be maintained by the organization.

PRTF staff must provide all necessary therapeutic interventions for PRTF residents. When on duty as PRTF staff, they do not provide services to individuals who are non-PRTF residents.

MRO outpatient service staff provide services only to individuals receiving services form the MRO outpatient services. When on duty as MRO outpatient service staff, they may not deliver services to PRTF residents.

Administrative staff may have oversight of more than one program. A shared administrator of an organization using separate assistant administrators for distinct programs or facilities has been permissible. Administrator's time and cost is divided among the programs according to established accounting principles (see Financial Separation section).

Staff Awareness

Staff should be able to delineate the differences between the programs. They should be able to describe the differences in services they provide for each program if they work in more than one.

Records Management

All programs/facilities must develop polices and procedures in accordance with state, federal and other regulatory entities' guidelines for the specific types of programs being

operated to ensure appropriate Records Management of patients, residents, clients, consumers served in their facility.

All client/resident files are to be separate and distinct between facilities/programs. All original files and records should remain within the facility and/or program type and should be filed and housed separately from files and records for other programs. Case files and clinical records cannot be transferred from one facility/program to another.

Discharge summaries and other pertinent information may be shared with other facilities and / or entities with the appropriate authorization and release of information documents. PRTFs should create polices and procedures to ensure that residents returning for re-admission shall have the appropriate updated information necessary to care.

Programmatic Separation

Licensure and Certification

Each program must obtain and maintain current licensure and/or certification, as required, for the type of program being operated.

Distinct Levels of Care

Organizations that operate both outpatient MH/AD services and psychiatric residential treatment facilities should clearly communicate in their overall policies and procedures and in their admission and discharge criteria the differences in the levels of behavioral healthcare provided in these two distinct programs.

Distinct Types of Care

Organizations that operate both a CCI/CPA and a PRTF should clearly communicate in their policies and procedures the nature of each program and the differences between the two should be readily apparent. They should delineate the different types of staff and services provided in each type of program, especially the differences between child care and behavioral health care and between child care workers and the functions of staff who work in behavioral healthcare.

It is important for PRTF program policies, procedures and descriptions to thoroughly describe the active treatment program provided. There will, of course, be activities that are not necessarily treatment interventions that will be part of a PRTF program (e.g. recreation and leisure activities) but it should be clear that the PRTF is not residential care but is psychiatric residential care that is focused on active treatment of a serious emotional disturbance that requires this level of care.

The CCI/CPA program documents should clearly document the functions of the CCI/CPA as a facility which provides residential care but which is not a treatment facility for youth with serious emotional disturbances. Children in a CCI/CPA who have medical needs or behavioral healthcare needs must receive treatment, but those services will be obtained just as if the child were living in his or her family home and the reason for his/her placement in a CCI/CPA is not for the purpose of treatment.

There can exist no arrangements or agreements between a CCI and an MRO provider that would explicitly state or imply that the MRO is providing services to the CCI. If a resident of a CCI needs behavioral healthcare services, they will access those services in the same manner as a child living in the community.

Literature about the Facility/Program

Informational brochures, marketing materials, directory listings, and any form of advertising material in any type of media (printed, electronic, websites) should clearly identify each as a separate facility or program with a different purpose and describing the different needs met by the services offered through each program. Letterhead and business cards should be examined and revised as necessary to reflect program separateness. All these materials should be updated no later than July 1, 2007.

Service to Community Residents – Prohibition against Self-Referral

Medicaid recipients have freedom of choice of providers. Therefore, organizations that make referrals for individuals in their care for other types of services (e.g. referral for aftercare for a child being discharged from a PRTF; assisting a CCI/CPA resident in accessing behavioral healthcare; referring an MRO client for PRTF services), may not self-refer individuals to services provided by their parent organization. They must offer a full range of choice of providers which may include their parent organization's services but must include freedom of choice of other available providers of those services. The provision of this free choice must be documented in the individual's clinical record or, in the case of a resident of a CCI/CPA, in the resident's file maintained by the CCI/CPA. We suggest that each agency develop a standard form that can be signed by the individual, parent, or guardian to confirm that a choice of providers was offered.

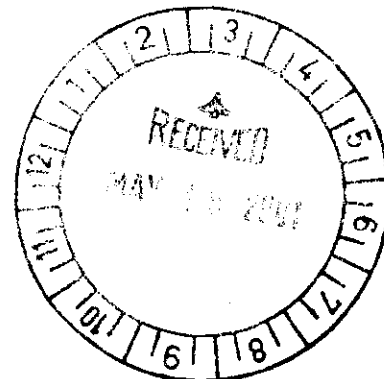
In addition, providers who have an MRO outpatient clinic must provide those services to the public and not primarily or exclusively to individuals who are receiving other types of care from the parent organization. The clinic must be accessible to the public (i.e. no locked gates encompassing the property containing the MRO clinic), accept referrals from other providers in the area and from sources such as MHDDAD's Crisis and Access line. Providers should be prepared at all times to demonstrate to state and federal officials how the provision of their services is in keeping with this requirement.

Appendices

Appendix A – HCFA Region 5 letters with Illinois state officials

JBX & Associates, Inc.
Excellence in management consultation

May 10, 2001



Carroll Benson, Director
Medicaid System Design and Revenue Maximization Section
Division of Mental Health, Mental Retardation and Substance Abuse
Department of Human Services
2 Peachtree Street, Suite 22-477
Atlanta, GA 30303-3171

Dear Mr. Benson:

While waiting to receive the telephone and fax numbers of the current crisis stabilization programs, I have secured copies of the Illinois' correspondence that should be helpful during our "phase II" work, assuming that the feasibility phase is positive. Enclosed find:

> Letter from Charles W. Hazlett, Associate Regional Administrator, Division of Medicaid, Health Care Financing Administration, Region V Office to Theresa H. Stoica, Administrator, Division of Medical Programs, Illinois Department of Public Aid (DPA), dated January 28, 1992 (attachment A):
>
> Letter from Theresa Stoica, Deputy Director, Medical Operations, DPA to James E. Long, Director, Illinois Department of Alcoholism and Substance Abuse (DASA), dated March 9, 1992 (attachment B):
>
> Letter from James E. Long, Director, DASA to Theresa Stoica, Deputy Director, Medical Operations, DPA, dated March 23, 1992 (attachment C); and,
>
> Page from Illinois Administrative Code, chapter X, section 2090.30, 8) concerning DASA Medicaid certification of sites within a facility of more than 16 beds (attachment D).

Attachment A is the HCFA letter that permitted Illinois to develop the distinct part certification program. HCFA says that if two licensed/certified service components of 16 beds or fewer that deliver different levels of care exist in the same building, they would not be considered an Institution for Mental Disease (IMD). Each entity (level of care) is to have its own staff, cost center, operating policies and procedures, etc. An example would be a building that houses a subacute detoxification unit and an adolescent residential substance abuse program. By extension, three or more levels of care that meet the same criteria would also not be considered IMD's.

Attachment B expands on the criteria based on discussions between HCFA and DPA, and emphasizes separate cost centers, physical location, clinical staffing, and levels of care. An existing memorandum of understanding between DPA and DASA delegates the provider certification function to DASA, and therefore DPA expects DASA to,

2375 Sloo Road • Springfield, IL 62707 • Phone (217) 544-5299 • Fax (217) 544-8092 • E-mail: Bixjbx@aol.com

"… incorporate a thorough review of individual treatment program status to measure degrees of separation across HCFA's factors or distinction".

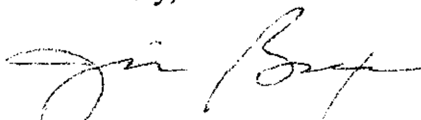
Attachment C further defines how Illinois will apply the "distinct part" criteria, especially for levels of care, physical separation and separate staffing. The interpretation of levels of care was expended to take into consideration specialized programs for adults such as hearing impaired and pregnant/post-partum women. The physical plant criteria will not prohibit scheduling of common areas such as a gymnasium or group meeting rooms across levels of care, and recognizes that some floor plans may require case-by-case decisions. Clinical staffing would be clearly defined through DASA's management information system and year-end financial and statistical reports.

Attachment D, item 8), is the administrative rule that implements the HCFA distinct part requirements, as elaborated by DPA and DASA, for provider certification by DASA.

I assume that, should the Atlanta Regional Office of HCFA approve a similar approach for Georgia, the Division and the State's Medicaid office would also complete similar implementation criteria and procedures.

I would be glad to answer questions about these materials, or to arrange for contacts with staff of the Office of Substance Abuse Services, Illinois Department of Human Services (the successor to DASA), or the Division of Medical Assistance, Illinois Department of Public Aid.

Sincerely,



J.B. Bixler
President

cc: John O'Brien, TAC

DEPARTMENT OF HEALTH & HUMAN SERVICES Financing Administration

Region V
105 West Adams
Chicago, Ill 60603

JAN 3 1992

DEPT. OF ALCOHOLISM & SUBSTANCE ABUSE
RECEIVED
FEB 0 3 1992
Directors Office-Springfield

JAN 3 1 1992
STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

Ms. Theresa H. Stoica, Administrator
Division of Medical Programs
Illinois Department of Public Aid
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Ms. Stoica:

Mr. Edward Zawislak, of my staff has had several conversations with members of your staff and staff of the Department of Alcohol and Substance Abuse (DASA) regarding the availability of Federal financial participation (FFP) under the Medicaid program for services provided to Medicaid recipients in residential facilities for the treatment of alcohol and substance abuse. This letter is intended to help clarify this issue which is complicated by the institution for mental diseases (IMD) exclusion.

As you know, facilities with more than 16 beds whose primary purpose is to provide residential treatment for alcohol and substance abuse are considered IMDs. There is no FFP available for any Medicaid services for residents of those facilities.

One issue that has been raised involves the downsizing of a facility. If a facility that was previously licensed/certified for more than 16 beds decides to downsize to 16 beds or less, we would expect the following conditions to be met:

1. that this is a permanent change reflected on licensure/certification documentation;

2. that the specific rooms/beds that now constitute the facility be designated and that all other rooms/beds be taken out of service or, in the case of rooms, used for other purposes than sleeping areas; and,

3. if there are other residential entities within the same building, that they be separately licensed/certified and meet the requirements indicated below.

A second issue involves the definition of a facility when there are multiple entities within the same building. The Health Care Financing Administration (HCFA) has not established regulations or policy regarding this issue when dealing with non-Medicaid certified residential facilities. However, we believe we can make logical comparisons using the policy related to Medicaid certified residential facilities.

When we look at the IMD issue in relation to Medicaid nursing facilities (NFs) we consider licensure/certification, the type of provider and the level of care provided. If two separately licensed/certified components exist in a building and both provide services at the same level of care (for example, the NF level of care) HCFA would consider these two entities together when determining IMD status. If two licensed/certified components exist in a building and each provides a different level of care (for example, one is a NF and the other is an

Chuck | Dennis | BJ FYI

FEB 03 1992

Directors Office-Springfield

intermediate care facility for the mentally retarded (ICF/MR)) HCFA would consider these two entities separately when determining IMD status. If one or both of these latter entities were less than 16 beds they would not be considered an IMD. When we talk about licensed/certified entities we assume that each such entity is independent, by this we mean that it has its own staff, cost center, operating policies and procedures, etc..

We believe that, when looking at non-Medicaid certified residential facilities, if you find that within a building there are independent entities that provide distinct "levels of care" you could logically consider them separately when making your determination of IMD status. This would be especially true if you or DASA identify/license/certify these entities separately. We understand that an example of such a situation might be a building that houses a subacute detoxification unit and an adolescent residential substance abuse program. We believe that if these entities had separate staff, cost centers, operating procedures, etc., they could be considered separately in determining IMD status. If these entities are determined to be distinct and are less than 16 beds they would not be IMDs and Medicaid services provided to Medicaid eligible residents would be covered and eligible for FFP. As you know, only reimbursement related to covered services would be allowed. No reimbursement related to room and board could be covered unless the facility was certified as a hospital, NF or ICF/MR.

We have provided the above information to assist you in determining whether to claim for Medicaid services. We are not, in this letter, approving any such claims nor are we indicating whether or not a given entity is or is not an IMD. IMD status is not a "certification" or permanent label. IMD status can change from time to time based on patient mix and a number of other factors. Any claim for FFP by the Illinois Department of Public Aid (IDPA) might be subject to financial review by HCFA or audit by the Office of Inspector General.

If you have any questions please call me or have a member of your staff call Edward Zawislak, Medicaid Program Specialist at (312) 353-5968.

Sincerely,

Charles W. Hazlett
Associate Regional Administrator
Division of Medicaid

cc: James E. Long, Director
Illinois Department of Alcohol and Substance Abuse

Copy to: Mark, Bob, Scott, Jim B, Ron, Sam - Gary B 3/12/9

Illinois Department of Public Aid

Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Phil Bradley
Director

(B)

March 9, 1992

James E. Long, Director
Illinois Department of Alcoholism and Substance Abuse
222 South College, Second Floor
Springfield, Illinois 62704

Dear Director Long:

Charles Hazlett's letter of January 29 provides new guidance with respect to HCFA interpretation of the Institution for Mental Diseases (IMD) exclusion and residential alcoholism and substance abuse treatment programs of 16 beds or less. This guidance represents a significant departure from our perception of HCFA's long-standing policy on this issue, as was described in Fred Sapetti's September, 1991 memorandum to Jim Bixler.

Although no published federal policy specific to community-based subacute residential treatment facilities currently exists, Mr. Hazlett has addressed the applicability of the IMD exclusion and the 16-bed threshold by drawing parallels from established HCFA policy for nursing facilities. This new interpretation greatly enhances the Medicaid eligibility potential of covered A/SA treatment services provided by both stand-alone subacute residential rehabilitation and detoxification programs located in single-use buildings, and qualified distinct programs operated in multiple program facilities.

In stand-alone programs, the new policy is easily applied. Treatment services provided by any licensed subacute residential rehabilitation or detoxification program that occupies an entire facility, may qualify for federal Medicaid match _if_ the number of program beds in active use in the total facility do not exceed 16. HCFA staff have suggested that physical removal of beds in excess of 16 is not necessary, but these extra beds must be closed off from the rest of the facility, stored away, or otherwise "retired" from use in the program. As long as no more than 16 beds are used in such a program, the facility is not considered an IMD and FFP can be claimed for reimbursed clinical services provided as part of the 24-hour care clients receive. FFP will be disallowed for Medicaid payments made during any time in which more than 16 beds are occupied in such a program.

This policy also applies to campus-style or "pod" program configurations. If, for example, clients reside in separate buildings but all receive similar clinical services in a another building or common area of the same facility, HCFA staff believe the total number of operational beds located in _all_ buildings comprising the program must be considered in applying the 16-bed threshold - even if less than 16 beds are located in each individual building or "pod".

Formerly, HCFA did not recognize distinct program breakouts within a common facility; all beds in a building were considered in applying the 16-bed criteria. Thus, detoxification and residential rehabilitation programs of 16 beds or less located in the same building were considered to constitute an IMD if the combined number of beds exceeded 16. Given HCFA's willingness to extend nursing facility criteria for determining distinct part status to community-based A/SA treatment programs, however, individual programs within a facility are now exempted from the IMD exclusion if they are clearly separate in 1) ownership, 2) administration, 3) cost centers 4) physical location, 5) clinical staffing, and 6) levels of care.

In subsequent conversations, HCFA staff have agreed that separation of ownership and administration is a rather unrealistic expectation that would promote artificial corporate restructuring and inefficient facility operation. It is thus necessary to place even greater emphasis on distinctions in cost centers, location, staffing and, especially, levels of care.

The inherent differences in client condition, clinical service provision, and staffing requirements between detoxification and residential rehabilitation reflect significantly different levels of care. DASA licenses such programs under different standards, and providers are routinely required by DASA to break out these costs separately on the ISFR. If two such programs located in the same building are separately licensed as residential rehabilitation and detoxification by DASA, if both consist of 16 beds or less, do not share clinical staff, and are clearly physically separate, both programs would qualify for Medicaid match under the 16-bed criteria.

Programs must be clearly separated by floors, wings, or other building sections to be considered separately located. Intermixed program beds on the same floor, or program beds separated only by groupings of dormitory rooms will not be considered truly physically separate. Likewise, programs which share common treatment, recreation, or sleeping areas - even if otherwise separate - will not fully satisfy the physical location criteria.

HCFA appears to be less willing to recognize program distinctions between commonly licensed programs - such as two residential rehabilitation programs within the same building - on the basis of gender or race specialty. They do, however, agree that distinct part criteria can be applied to programs located in the same facility which specialize in adolescent vs. adult residential rehabilitation or detoxification given the need for significantly different clinical approaches to these special populations - provided all other distinction requirements are met.

It is our understanding that the DASA's established Medicaid certification process will incorporate a thorough review of individual residential treatment program status to measure degrees of separation across HCFA's factors of distinction. In order for this Department to enroll programs of 16 beds or less as day detoxification or day treatment providers in the subacute Medicaid initiative, it will be necessary for DASA certification to ensure program qualification both in terms of the number of operational beds and in program compliance with the distinction criteria.

Excluded from federal match in qualified programs is reimbursement for the domicile service components provided by such programs, including room and board, meals, other support or "hotel-type" services, night dormitory coverage or supervision, and allocated administration, capital, and usage of multi-use facility space such as recreation areas, public restrooms and waiting areas, meeting rooms, etc. Only hospital-based subacute residential treatment programs or youth residential programs located in JCAHO-accredited psychiatric facilities are eligible for full per diem Medicaid match. Your proposed modification of the existing residential rehabilitation rate methodology to identify and separate costs specific to clinical vs. domicile costs, described in Bob Stachura's recent letter, is a sound method of calculating a matchable partial per diem rate for what we will call "day treatment" services in qualified residential rehabilitation programs of 16 beds or less. I understand your Office of Purchased Care Development is developing a similar approach to breakout per diem reimbursement for "day detoxification" in such a manner. I also understand that payment for the non-matchable portion of the 16-bed per diem rate will be funded from DASA's non-Medicaid residential treatment appropriation, via the established DASA fee-for-service mechanism.

I hope this letter more fully clarifies current Medicaid policy on qualified 16 bed and under programs. My staff are currently working with your Chief Legal Counsel, Nancy Bennett, to develop new service definitions and administrative rule changes. We are also drafting State Medicaid Plan revisions and establishing four new procedure codes to allow invoicing for youth and adult day treatment and day detox services. We look forward to enrolling qualified programs and increasing federal match for subacute A/SA treatment, once you begin certifying and setting rates for these new services.

Please let me know if you have any questions regarding our implementation of this new coverage.

Sincerely,

Theresa Stoica, Deputy Director
Medical Operations

WPP007-10855

STATE OF ILLINOIS
DEPARTMENT OF ALCOHOLISM AND SUBSTANCE ABUSE

STATE OF ILLINOIS CENTER
100 WEST RANDOLPH STREET
SUITE 5-600
CHICAGO, ILLINOIS 60601
OFFICE NUMBER: (312) 814-3840
TDD NUMBER: (312) 419-8432
FAX NUMBER: (312) 814-2419

Jim Edgar
Governor

James E. Long
Director

March 23, 1992

RECEIVED
MAR 27 1992
DEPARTMENT OF ILLINOIS
DEPT. OF ALCOHOLISM AND SUBSTANCE ABUSE
SPFLD. D.U.I. SECTION

Theresa Stoica
Deputy Director
Medical Operations
Illinois Department of Public Aid
Prescott E. Bloom Building
201 South Grand Avenue East
Springfield, Illinois 62763-0001

Dear Ms. Stoica: Terry

I am responding to your letter of March 9, 1992 concerning HCFA's new interpretation of the requirements for Medicaid reimbursement for residential substance abuse treatment services at facilities having 16 beds or fewer.

The Department appreciates DPA's and HCFA's efforts to extend the parallels for "distinct part" facility certification from nursing homes to substance abuse programs and this new interpretation is of significant value to us in expanding the availability of residential substance abuse services to Illinois' Medicaid recipients. The application of the new interpretation to stand-alone, single service facilities is straightforward. We are now in the process of certifying six (6) such facilities, as defined in paragraph three of your letter.

However, when we apply this interpretation to other program models, we begin to encounter a number of interpretive situations. We are clear about three of HCFA's criteria: program policies and procedures; Medicaid certification and licensing requirements; and cost reporting.

Our concerns arise in the following areas:

A. Levels of Care

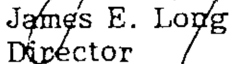
Regarding levels of care, we have discussed the issues with your staff and we have come to an understanding that two or more programs of 16 beds or fewer in a single facility for adults (or adolescents) can be certified when the program serves the hearing impaired, pregnant and post partum women and their infants, or other similar populations which require distinct clinical services. We have also agreed that

It is our goal to implement this expansion of services as soon as possible in FY'92. Our legal staff have completed discussions with your staff and have drafted a revised Part 2090 for First Notice at JCAR. The rule was submitted to JCAR yesterday. In addition, DPA staff have agreed to incorporate these changes in a State Plan amendment.

I appreciate your commitment to maximizing federal financial participation for substance abuse treatment services, and your leadership in restoring access to residential substance abuse treatment for those Medicaid recipients who will use the programs certified under this new interpretation. Moreover, I believe our suggestions as noted above are fully consistent with Mr. Charles Hazlett's January 22, 1992 letter to you clarifying HCFA's position on the IMD exclusion. Therefore, I would hope that you are comfortable and concur with our suggestions. I trust that we might resolve these questions on Friday following our meeting with DCFS.

Thank you for your help and consideration.

Sincerely,



James E. Long
Director

cc: Bob Roodhouse
Mark Bishop
Bob Stachura
Dave Dierks
Sam Gillespie
Ron Vlasaty

6) Certification is site-specific and services are to be provided on-site, unless they are provided in accordance with the off-site service provisions as set forth in 77 Ill. Adm. Code 2060.203.

7) Sites providing 24 hours of services to clients and having more than 16 beds shall not be certified for Medicaid enrollment for other than residential rehabilitation services.

8) In order to receive certification for a site having 16 beds or less, a program must meet the following criteria:
   - A) be a free-standing program of 16 or fewer beds; or
   - B) be within a larger facility, as a distinct unit of 16 beds or less, which:
     - i) is licensed;
     - ii) is physically separate from other certified and licensed programs (for example, separated by floors, wings, or other building sections);
     - iii) provides a level of care significantly different in clinical content from other certified and licensed programs (for example, adult versus adolescent care, women versus men, hearing impaired versus non-impaired);
     - iv) has a separate cost center (budgeting, accounting, etc.);
     - v) has separate staffing; and
     - vi) has separate operating policies and procedures.

9) Prior to certification, the Department shall conduct an on-site inspection.

10) Based upon the on-site inspection and a review of the application for certification, the Department will certify the program if the Department determines that:
   - A) the applicant has proven that an unmet need for the services exists in the community the program will serve;
   - B) the organization operating the program is fiscally sound and responsible;
   - C) the program management is experienced in business and in the delivery of substance abuse services;
   - D) the program has sufficient written agreements with social, medical and other substance abuse service providers within its area to assure proper linkage of services to an individual;
   - E) the program has experience with the Medicaid eligible population it intends to serve;
   - F) the program has adequate physical facilities and adequate numbers of professional staff to provide the services;
   - G) the program conducts utilization review and has a quality improvement plan; and
   - H) the program has a measurable outcome evaluation process in place that provides measurable indicators of improvement by program participants.

Appendix B – Provider Cost Report Instructions

Out-of-Home Care

Georgia Department of Human Resources

State Fiscal Year 2008

Provider Cost Report
Instructions & Forms

Instructions for Completing the Cost Report

INTRODUCTION

For the Georgia Department of Human Resources and Department of Juvenile Justice to determine the actual cost of providing out of home care services to the children of Georgia, cost reports must be submitted annually. The cost report will enable the State to establish an appropriate base for reimbursement.

The four sets of information that are required to be submitted annually are:

> Annual Cost Report: This report will be used by the Department of Human Resources and Department of Juvenile Justice to determine the cost of care for program planning purposes and for reimbursable costs incurred in the provision of out of home care. This report should reflect the provider's most recently completed fiscal year.
>
> Independent Audit Report: This should be the most recently completed 12-month financial audit for the provider. The audit report should be submitted with the annual cost report described above. Note: For profit corporations are required to submit an audited cost report using Circular A-133 guidelines in lieu of a corporate audit.

FACILITIES REQUIRED TO REPORT

All providers of residential child care or foster care for the Departments of Human Resources and/or Juvenile Justice are required to submit the above documents. Licensed programs of out-of-home care include:

- Child Caring Institution
- Child Placing Agency
- Emergency Shelter
- Teen Development
- Second Chance
- Maternity Home
- DJJ Specialized Residential

AGENCIES WITH MULTIPLE PROGRAMS/MULTIPLE SITES

A cost report, program description and sample schedules are required for each program site and those with a different functional component. For example, an agency operating both a residential program and a foster care program must submit cost reports for each**.** This would also be true of an agency operating both a residential program and a separate emergency shelter. Providers shall include their current LOC Program number on each the cost report.

Agencies that operate programs with multiple sites of the same type program ***must*** prepare a cost report for each site.

For purposes of this report, a facility may allocate common costs using a method that is reasonable. There are two general types of common costs requiring different allocation methods. Facility costs, for example, rent for one building that houses two or more programs, must be allocated based on the proportion of the square footage occupied by the different programs. Administrative overhead shall be allocated based on proportional program cost using the Modified Total Direct Cost methodology as defined in OMB Circular A-122. The basis for allocation of costs should be should be recorded and maintained with the work papers supporting the cost report. Agencies should confer with their auditors to ensure that they are using federally approved and generally accepted accounting practices in the allocation of shared costs to the program cost center

Please note the spreadsheet has calculations built in for some cells and this is indicated by a $0 or #DIV/0 in the cell. These cells have been locked. Please, do not attempt to overwrite the calculations.

REPORTING PERIOD

The cost data in the report should reflect the facility's most recently completed fiscal year. The report must reflect the actual incurred cost during the time period reported. Do not include anticipated costs that are outside of the reporting period nor budget estimates.

GENERAL GUIDELINES FOR COMPLETING THE COST REPORT

The cost reports are used in rate setting as well as establishing the basis for federal reimbursement. As such they are subject to federal and state audit. The instructions for allowable and unallowable costs and expenditures for federal claiming are based on federal criteria. These are identified in the Office of Management and Budget Circulars A-122, A-133 and A-87, "Cost Principles for Nonprofit Organizations " , "Audit Principles for Non Profit Organizations" and "Cost Principles for State and Local Governments." These instructions for completing the Cost Report are meant to explain and apply these federal criteria, not to displace or contradict these criteria. In any area of dispute, the force of the federal guidelines will prevail. Allocation of reasonable costs to the program shall be supported by approved methodology and documentation retained by the reporting agency.

Take special care to be accurate and consistent in completing this report. The cost report is subject to federal audit, and any inaccuracies could lead to repayments to the federal government for any unallowed or inaccurately reported costs.

Do not use terms such as "miscellaneous", "various", "etc.", or "other", without specifying the items. State staff must be able to determine that costs are allocated to the appropriate cost categories, and the use of such terms makes it impossible to do that.

The chart of accounts used in this report is designed to capture federally allowable costs. If your facility's Chart of Accounts is not as detailed or somewhat different, then consolidated amounts for the major non-personnel costs are acceptable.

SUBMITTAL INSTRUCTIONS

The cost report and accompanying materials are to be completed and postmarked no later than, **March 30 , 2007**. An emailed copy of the cost report must also be received at email addresses below by March 30, 2007

Submit completed e-mail Cost Reports to:

marywilloughby@bellsouth.net

and

raoneill@dhr.ga.gov

Submit completed signed Cost Report Cover Sheet and Audits to:

Georgia Department of Human Resources
Office of Planning and Budget Services
2 Peachtree Street NW, Suite 19-442
Atlanta, GA 30303-3142
Attn: Mr. Richard O'Neill

COVER SHEET

Reporting Period: The Cost Report must reflect the provider's most recently completed 12-month fiscal period. The period being covered should be noted either as the start and end dates of a full fiscal year or the dates a program started or ended for less than full year reports. For a program accepting children for less than six months during the reporting period, contact Richard O'Neill via e-mail at raoneill@dhr.ga.gov to see if a cost report will be required.

Identifying Information of the Operating/Parent Agency:
Enter the legal name, mailing address and telephone and fax numbers of the parent organization which administers the program represented in this report.

Identifying Information of this Program:
Enter the name, ***current*** LOC vendor number per provider listing, mailing address and telephone and fax numbers of the program, which this report reflects. The current LOC provider list with numbers can be found on the web at galocweb.com on the LOC contract page under printable documents as "DFCS approved provider list".

Program Type: Per the LOC provider list described above, check the primary type of program represented in this report. If 'other' is selected, specify the type in the space provided. Licensed program types are:

Child Caring Institution

Child Placing Agency
Emergency Shelter
Teen Development
Second Chance
Maternity Home
DJJ Specialized Residential

Hardware Secure: Check the area indicating whether this is a hardware secure program. **Hardware secure means that the doors are always locked and the children cannot exit without a staff person unlocking the door.**

Program Category: Check the appropriate category based on the following definitions:

- Private Non-Profit – privately owned and operated program with IRS status as a non-profit.
- Private For- Profit – privately owned and operated program that is for profit and does not have an IRS non-profit exemption.
- Public – publicly operated by state, county or city government.

Certification of Accuracy: Enter the name, phone, FAX, e-mail, and signature of the person completing the cost report.

Enter the name, phone, FAX, e-mail, and signature of the authorized agency representative certifying that the cost report is accurate.

Enter the name, phone, FAX, e-mail, and signature of the auditor certifying that the cost report is consistent with the required annual audit for the same period. A program reported in the cost report may represent only a portion of the agency audited. In such a case the auditor's certification indicates his/her ability to account for the items reported in the program cost report as non-duplicated parts of the whole agency audit, and whose allocation to the program is consistent with reasonable accounting standards.

CAPACITY AND UTILIZATION – Page 1

This section is very important in computing the "per day" cost of the program. The entries in these columns must have supporting documentation such as invoices or accounts receivable available upon request. It is extremely critical that utilization data accurately reflect the days according to payer source.

Capacity: This section reflects how many children the program is licensed to serve. Using the instructions listed below the data box, enter the licensed capacity of the parent agency, the licensed capacity of the residential program reflected in this report, and the maximum capacity of the program if that differed from the licensed capacity. An example of the latter would be a program licensed for 20 children, but which functioned for the entire period with a maximum of 16 children. Attach a memo describing the need or reason for functioning below licensed capacity when reporting a maximum capacity less than licensed capacity.

Foster care programs should enter the average number of children served monthly, as there is not a licensed capacity for those programs.

Utilization: In the appropriate box, enter the number of days of care provided for each payment source category on the correct line and agency in the column. One filled bed equals one day of care provided. These days should have been invoiced and may or may not be paid. In the Count of Children column enter the unduplicated total number of children served for that payment source and agency for the reported year.

PERSONNEL COST DETAIL – Page 2

This schedule should include the salaries of the staff employed by the agency that work in the program covered in this cost report. Include all remunerations paid or accrued for services rendered during the period of the cost report. If the employee works less than full time or works in other programs indicate the % FTE for this program. Use the formula to include correct percentage of salary in the Program amount column 2 (See the ALLOWABLE COST GUIDELINES)

Name: Enter name of employee.

Position Title: List the actual job titles. Use abbreviations and acronyms that are universally understood. For example, use "Ch. Care Wrkr." not "C.C.W." or "Exec. Dir." not "E.D."

Staff (FTE): Enter the percent of "Full Time Equivalent" for the person in the program. A position filled for 12 months at the agency's customary number of workweek hours would equal one FTE. A position filled for 12 months at half the agency's customary number of workweek hours would equal 0.5 FTE. A working fulltime for the agency but only one day per week in this program would be 0.20 FTE

COLUMN 1 -3 . Allocation of the Annual Salary:

After recording % FTE to the program, enter the total employee's annual salary. Multiply column 1 by the percent FTE for the program and record it in Column 2. Describe the allocation basis for all FTE less than one in column 3.

> For example, an executive director manages a residential treatment program and an emergency shelter program spending 25% of his***/her*** time on the residential treatment program and 75% of his time on the emergency shelter. A separate cost report is required for each of the two programs.
>
> On the cost report for the residential treatment program, all of the director's annual salary would be entered in Column 1 and multiplied by the 0.25 reported in the program % FTE column for a total program amount in column 2. On the cost report for the emergency shelter, 75% of the director's annual salary would be entered in Column 2.
>
> Note: The FTE should reflect the percentage of the salary distribution (i.e., for the residential treatment program, the director's FTE should be .25 and for the emergency shelter program, the director's FTE should be .75) and the Basis in column 3 should describe the allocation methodology e.g. time study sample, program % total operations, etc.

NOTE: The salaries of administrative staff who perform both general administrative activities and activities that are unallowable for federal claiming (e.g., research, fund raising) should only have time for allowable activity allocated to the program. For example, an assistant director who spends half-time managing the program and half-time fund raising would have 50% of his salary in Column 2 for the management portion of his time and the unallowed activity would be excluded. Unallowed activities include fund raising activities, research activities, and religious services.

ROW B. Total Fringe Benefits

For all positions listed above in Section "I. Personnel/Costs," enter the proportionate total of the employer's share of Social Security, Worker's Compensation, Unemployment Insurance, retirement, health and hospitalization benefits, employee life insurance, official employee "training allowances," and any other fringe benefit payments in Row B, Column 1.

If the employer pays the cost of professional liability insurance for employees who are individually covered, these costs should be included in this section. If professional liability insurance for the operating agency as a whole is obtained through a group policy, the cost of the group policy is to be listed in CONSUMABLE SUPPLIES AND MISCELLANEOUS EXPENSES.

CONTRACTOR, CONSULTANT AND PERSONAL SERVICES COSTS – Page 3

This section is for the cost of fees that were paid for services of outside agencies or persons not on the regular payroll of the agency and for whom no fringe benefits were paid. List the type of jobs or functions performed, not the name of the agency or individual. Costs should then be reported in either the direct program amount column 2 for contracts fully charged to the program or allocated amount in column 3 with the basis for allocation noted in column 4(s).

> For example, fees for audit of the financial statements should be listed in Column 3 for an agency with more than one program and the cost allocation basis noted in column 4. Program-related charges, such as clinical consultation should be entered in Column 2 as direct program costs.
>
> Payments made to foster parents for the customary care (e.g., food, clothing, shelter, incidentals, school supplies, gifts, etc.) of children placed with them, should be entered in Column 2 on the designated line.

ROW A. Total Contractor Costs

The sum of column 1 should equal the sum of columns 2 and 3.

ROW B. Indirect Agency Costs

Indirect costs are for common or joint purposes benefiting programs or services of the agency that are in addition to the costs included in this report. Indirect costs, if any, should be computed according to the accounting procedures used by the operating agency.

Indirect costs are typically costs that are assessed to the specific program by the parent agency for providing administrative services such as payroll and accounting, advertising or training. Indirect costs must meet the allowable cost definitions.

Enter the total indirect cost in Column 1. Indirect Costs using allowable cost descriptions must be specified on **Attachment A**.

CONSUMABLE SUPPLIES AND MISCELLANEOUS EXPENSES – Page 4

Enter the total or annual costs for consumable supplies or miscellaneous expenses in Column 1. Then using columns 2 or 3 indicate whether the costs were direct to the program or allocated from the agency whole. For all costs reported in column 3 indicate the allocation basis in column 4.

Consumable supplies are generally those items that are used up within one year. The cost of food, household supplies, medical supplies are most appropriate for the Room and Board column. Miscellaneous expenses such as printing, postage, telephone costs, liability insurance, licensing fees and professional memberships are generally administrative costs.

Records specifying miscellaneous expenses should be maintained by the facility for audit purposes.

Total Consumable - Total the amounts listed in Columns 2 and 3. The totals of Columns 2 – 3 must equal the total for Column 1.

PROGRAM COST DETAIL – Page 5

OCCUPANCY COSTS – Item 1

Enter the occupancy costs for the program, which were paid as rent or mortgage interest if the provider owns the building. If the occupancy costs are based on a mortgage, it is important to separate the principal portion of the mortgage, which is unallowable, from the interest portion of the mortgage, which is allowable. Report mortgage interest only on line A, rent only on line B. Depreciation is not a reportable expense. For agencies with multiple programs include only the allocable portion of common area occupancy costs and describe the basis in column 3.

The cost of insurance, utilities, property taxes, maintenance, and repair is also allowed as part of the occupancy cost.

If there is an on-campus school, then the occupancy costs for the school must be excluded as Education related expenses are not allowable for per diem out of home care.

Occupancy Cost Total - Enter the totals for each of the columns and add the two for the grand total.

TRAVEL COSTS – Item 2

Travel costs include both the cost of operating and maintaining agency-owned vehicles, and the cost of purchased transportation (e.g., bus tickets and taxi fares). Reimbursement for staff mileage is to be listed at the actual rate paid. Expenses for travel to conferences and meetings that pertain to the program or operation of the program may be allowed as travel costs.

Be sure to separate the cost of purchased transportation for clients from the other travel costs. Enter purchased client transportation costs on line A.

Line B, Agency Vehicle Operating Costs, should include gas and any maintenance costs associated with a facility-owned vehicle. The cost of buying or leasing a vehicle should be listed as an Equipment Cost (see Section 3 below).

Allowable Travel Costs do not include the cost of operating a vehicle for the exclusive use of any employee of the program. This should be treated as staff income and be entered as a Personnel Cost.

Total Travel Costs - Enter the totals for each of the columns and add the two for the grand total.

EQUIPMENT – Item 3

Equipment costs are an allowable expense if used in support of the program included in this cost report. Equipment includes: Copy machines, computers, washing machines, etc., which are purchased for use by residents and staff. Agency vehicle purchase costs are included in this category. The cost of rental or maintenance of equipment is an allowable expense.

Equipment costing less than $5,000 may be fully expensed. Equipment costing more than $5,000 should be depreciated based on the life expectancy schedule in the Internal Revenue Code. Adequate records must be available for audits.

If the loan payment for the purchase of equipment or vehicles includes principal and interest, then the interest portion is allowed and must be reported separately and entered on line A. The principal amount is excluded.

Equipment Cost Total - Enter the totals for each of the columns and add the two for the grand total.

REVENUE SOURCES – Page 6

The revenue sources and the amounts received for the programs are important in order to offset any costs that have already been subsidized by federal payments made directly to the program. Otherwise the federal reimbursement calculations based on these cost reports would result in "double dipping" which is illegal.

The revenues listed on this page must be for costs or reimbursement for costs that are included in this cost report period. The total revenues should be greater than or equal to the costs that were reported on pages 1 through 4. If the revenues are less than the costs, please give a brief reason as to the discrepancy.

Enter the dollar amount of revenues received according to the schedule (i.e., USDA, SSI, education, DFCS, DJJ, other public agencies, private fund sources).

COST REPORT AND AUDIT RECONCILIATION - Page 7

This summary page is designed to identify and explain any variances between total program costs and total program revenues as reported in the Cost Report and audited program costs and revenues. Programs whose most recently completed fiscal year has not yet been audited should make that notation at the top of the page.

Program Cost

Enter the totals from the preceding pages on the appropriate lines and sum. Enter the total program cost (categorical breakdowns not necessary) as reported in the Audit. If the two are not the same, display the

difference as a Variance on the designated line and explain at the bottom of the page (additional pages may be attached as necessary).

Program Revenues

Enter the revenue totals by category on the appropriate lines and sum. Enter the total program revenue (categorical breakdowns not necessary) as reported in the Audit. If the two are not the same, display the difference as a Variance on the designated line and explain at the bottom of the page (additional pages may be attached as necessary).

ALLOWABLE COST GUIDELINES

SALARIES - Include all remuneration, paid currently or accrued, for services rendered during the period of the cost report. The costs for such compensations are allowable to the extent that the compensation is: (1) reasonable for the services rendered, and (2) it is supported by documented payroll vouchers or a generally accepted documentation method. Time and attendance or equivalent records must further support payroll for individual employees. Salaries of employees chargeable to more than one program or cost center must be supported by appropriate time distribution records. The method used should produce an equitable distribution of time and effort.

PAYROLL RELATED EXPENSES - Employee benefits in the form of employer contributions to social security, state and municipal retirement systems, life and health insurance plans, unemployment insurance coverage, workers' compensation insurance, and pension plans are allowable.

1. Incentive Compensation -- Such payments to employees based on cost reduction, or efficient performance, or suggestion awards are allowable to the extent that the overall compensation is determined to be reasonable and such costs are paid or accrued pursuant to an agreement entered into in good faith between the operating agency and the employees before the services were rendered, or pursuant to an established plan followed by the operating agency so consistently as to imply, in effect, an agreement to make such payment.

2. Deferred Compensation -- Such cost is available to the extent that (1) except for past service pension and retirements costs, it is for services rendered during the period of the cost report; (2) it is, reasonable in amount; (3) it is paid pursuant to an agreement entered into in good faith between the operating agency and its employees before the services are rendered, or pursuant to an established plan followed by the operating agency so consistently as to be, in effect, an agreement to make such payments; (4) the benefits of the plan are vested in the employees or their designated beneficiaries and no part of the deferred compensation reverts to the employer; (5) in the case of past service pension costs, it is amortized over a period of ten years or more; and (6) for a plan which is subject to approval by the Internal Revenue Service, it falls within the criteria and standards of the Internal Revenue Code and regulations of the Internal Revenue Service.

3. Severance Pay -- also commonly referred to as dismissal wages, is a payment in addition to regular salaries and wages, by operating agencies to employed workers being terminated. Costs of severance pay are allowable only to the extent that, in each case, it is required by (1) law, (2) employer-employee agreement, or

(3) established policy that constitutes, in effect, an implied agreement on the operating agency's part.

CONSULTATION FEES - The cost of consultation fees, charges for the use of personal services of outside agencies or persons not on the payroll of the contracting agency, are allowable to the extent that they are necessary for the management of functions relating to the provision of services, (i.e., audit service, legal counsel, and specialized consultation).

TRAVEL - Reimbursement is allowable for the costs of operation, maintenance, and repair of agency vehicles when relevant to the delivery of services. Expenses for transportation, lodging subsistence, and related items incurred by employees who are in a travel status on official business, related to delivery of services, are allowable either on an actual basis or a per diem and mileage basis. Expenses for meetings and conferences are allowable if the primary purpose is the dissemination of technical information relating to services. Purchased transportation is allowable if incident to delivery of services.

CONSUMABLE SUPPLIES AND MISCELLANEOUS EXPENSES - The cost of materials and supplies as well as the costs of maintaining a central storeroom are allowable to the extent that they are necessary to provide services. Direct charges to services should be based upon the actual price less cash discounts, trade discounts, rebates and allowances. Consumable supplies are those items, which will be used upon, or consumed within, the reporting period of the cost report.

Miscellaneous expenses could include printing and postage, telephone costs, licensing fees, professional organization memberships, conference fees, employee medical expenses, advertising costs, children's allowances, school supplies, admission fees, and other program costs.

OCCUPANCY COSTS - Rental or Privately Owned Building -- The non-interest portion of the cost for space is unallowable. The lease agreement must stipulate the extent of the lessor's responsibility for renovations. Major renovations, which add to the permanent value of the property or appreciably prolong its life, the cost of which is borne by the provider, must be depreciated.

1. Rental of Publicly Owned Building -- The rental cost of publicly owned buildings is allowable if the charge does not exceed the cost of ownership. The rental charge should include the cost of service, maintenance, depreciation on the building, and depreciation of major renovation.

UTILITIES - Utility costs for related facilities are allowable when equitably distributed among programs and cost centers.

INSURANCE COSTS - Cost of insurance in connection with the general conduct of activities is allowable to the extent that the cost will be in accordance with sound business practices. Building insurance and agency vehicle insurance are examples of allowable costs. The deductible portion of the insurance coverage in the event of loss or minor uninsurable losses is also allowable.

Unallowable insurance costs would be the cost of insuring the life of any officer or employee, for which the agency is a beneficiary.

LEASED EQUIPMENT - The cost of leased equipment is allowable if it is for the program and is reasonable as sound business policy.

MAINTENANCE AND REPAIR - Costs incurred for necessary maintenance repair and upkeep of equipment is allowable.

PURCHASED EQUIPMENT - Small equipment necessary in providing services may be expended during the period in which it is purchased. For larger purchased equipment, the payment on the interest is allowable.

DEPRECIATED EQUIPMENT - Computation of depreciation should be based on the criteria and standards of the Internal Revenue Code and regulations of the Internal Revenue Service. Records of depreciation schedules must be maintained for audit purposes.

LEASE PURCHASE - The cost of equipment or facilities obtained under a lease purchase arrangement is allowable to the extent applicable to the cost of ownership (e.g., depreciation, utilities, maintenance, and repair).

UNALLOWABLE COSTS

BAD DEBT - Losses arising from uncollectible accounts and other claims and related costs are unallowable.

CONTINGENCIES - Contributions to a contingency reserve or any similar provision for unforeseen events are unallowable.

CONTRIBUTIONS AND DONATIONS - Outlays of cash with no prospective benefit to the facility or program are unallowable.

ENTERTAINMENT - Costs of amusements, social activities, and related costs of staff and board members are unallowable.

FINES AND PENALTIES - Cost of fines and penalties resulting from failure to comply with federal, State and local laws or imposed by a court are unallowable.

FUND RAISING - Costs of organized fund raising are unallowable.

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

PROHIBITED ACTIVITIES - Costs of prohibited activities for Internal Revenue Code Section 501 (c) (3) Organizations are unallowable.

ORGANIZATIONAL COSTS - Organizational costs such as incorporation, fees to accounts, brokers, etc. in connection with establishment or reorganization are unallowable.

Appendix C – Cost Allocation Principles Presentation

Cost Allocation Principles

For Out-of Home Care Providers with Multiple Programs

- As sub-recipients of federal funds for Child Welfare services contracted Out of Home Care providers must comply with Federal Cost Principles
- The two types
  - for local governments Circular A-87 (2 cfr 225)
  - For non-profits Circular A-122 (2 cfr 230)

- For state, local government and nonprofit recipients of federal funds the audit guidelines are found in OMB Circular A-133 and the Circular A-133 Compliance Supplement

Why do costs get allocated

- When an agency does more than one type of program or delivers program in more than one location
- To distribute shared costs for space/physical plant among programs
- To distribute shared costs for administration among programs

- To be sure that the costs for services are fair and reasonable. E.g. can’t charge all the cost for a building to one program and none to the other using the building because one has more funding.

What gets allocated

- What is not direct – most of the expenses for a program are able to be directly associated with the activity.
- Some – indirect - cannot such as payroll services, auditing, human resources.
- Indirect costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective

- There are two big areas (or pools) of cost that get allocated according to two different principles

How – Physical Plant/Occupancy

- Facilities - the costs associated with rent, maintenance, utilities etc in a shared space is allocated to activities based on the amount of space occupied by the program.

How - Administration

- Most agencies isolate the costs for administrative staff, the HR, accounting, Executive Director etc into their own cost center including salary, benefits and supplies associated with those functions.
- To the extent these costs are allowable then they can be distributed to the agency’s program cost centers/expenses

Administration cont'd

- For example the agency has a $1million operating expenses
- Administration costs were $150,000
- Shared Facilities costs were $100,000
- Programs were $750,000
- Indirect rate is 150/850 = .20

Program example

- The agency operates 3 programs
  - Community Based Medicaid rehab op
  - CCI residential care
  - CPA foster care
- The CCI costs w/o administration were $325,000 times the admin cost % of 0.20 = $65,000.

Reporting Indirect Administration

- The amount from this example of $65,000. Would be shown on line B of Schedule 2, then Attachment A would summarize the administrative costs by allowable categories and show the calculation of indirect % to programs.

Reporting Occupancy

- In the cost report the program % of total occupancy costs is listed in column 3 and applied to the total occupancy costs to derive the program occupancy or facility costs.
- See Schedule 5
- Assuming this program occupied 60% of the facilities managed by the agency then the occupancy total would be $100,000 * 60% = $60,000

Total Direct and Indirect

- The total program cost then is the allowable direct expenses of $325,000 plus the allocated administrative costs of $65,000 plus occupancy of $60,000 for a program total cost of = $450,000.

- (4) General administration and general expenses. General administration and general expenses shall be allocated to benefitting functions based on modified total direct costs (MTDC), as described in subparagraph D.3.f. The expenses included in this category could be grouped first according to major functions of the organization to which they render services or provide benefits. The aggregate expenses of each group shall then be allocated to benefitting functions based on MTDC.

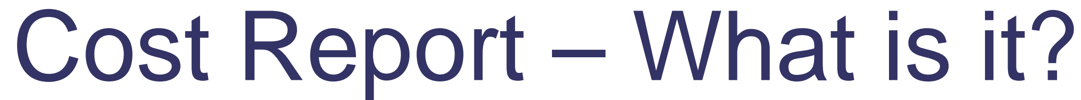
- MTDC consists of all salaries and wages, fringe benefits, materials and supplies, services, travel

Appendix D – Georgia Out-of-Home Care Cost Report Training for SFY2008, Presentation

Mary Willoughby, Consultant

Why do we do this every year?

- This process is used to:
  - Find costs for all out of home care services
  - Distinguish costs by services provided
  - REQUIRED to be done annually by fund sources and in your contracts



Cost Report – What is it?

- The cost data in the report should reflect the facility's most recently completed fiscal year.
- The report must reflect the actual incurred cost during the time period reported.

- to determine the actual cost of providing Out of Home Care services including: residential childcare and foster care.
- to enable the State to establish an appropriate base for reimbursement

Who submits Cost Reports

- All providers of residential child care and foster care for the Departments of Human Resources and/or Juvenile Justice are required to submit Cost Reports that include:
  - Annual Cost Data
  - Independent Audit Report
  - Typical weekly Schedule
  - Description of child care program

- A cost report, program description and sample schedules are required for each program with a different structural component e.g.
  - CCI
  - Emergency Shelter
  - Second Chance
  - Maternity Home
  - Camp
  - CPA
  - Specialized Residential (DJJ)

When is Cost Report done?

- As Soon As possible after close of fiscal year

- Must be sent to DHR no later than

Friday March 30, 2007.

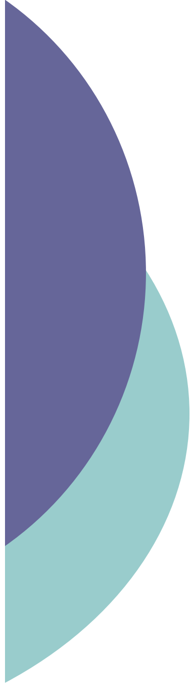
Generally Accepted Accounting Standards

- Use chart of accounts provided to report costs – avoid use of "miscellaneous" since all must be explained
- If allocating overhead use standard principles of cost allocation and define (Circular A-122)
- Actual costs – all are subject to federal and state audit, all must be allowable and documented

Cost Report Cover Sheet

- Program Type: Check the primary type of program represented in this report. If 'other' is selected, specify the type in the space provided.

- Fiscal year is most recently completed fiscal year ended in 2006
- Expect audit to match –Auditors signature certifies unduplicated costs from agency audit
- Legal name of parent agency may be different from program name – multiple programs
- Signature is legally binding commitment that information is accurate



Program Type

Program Type

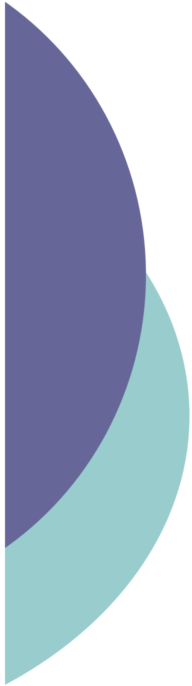
	Program Type **(X only one)**
	CCI
	Maternity
	Second Chance
	Teen Development
	Emergency Shelter
	Camp
	CPA
	Specialized Residential (DJJ)
	Other (Specify)

Cost Report Utilization pg 1

- Very Important information – do not skip do not estimate
- This is the basis for per day costs
- Capacity is licensed maximum – if operating consistently at less than licensed capacity note line 3

Utilization cont'd

- Report both the total number of days by payment type AND the total number of children by payment type
- Unduplicated count of children by level for the year is **VERY important** for per diem rates.



Utilization Table

Program Utilization by payment type	Number of Days Provided during the cost report period	Unduplicated Count of Children Served
DFCS Per Diem		
DJJ Per diem		
Division of Mental Health		
MAAC (Multi- Agency Alliance for Children)		
Other public (local governments, other states)		
Total	0	0

Instructions - One bed filled = 1 day of care provided

Personnel Cost Salary Detail pg 2

- NEW - this is a person based schedule no longer position based.
- This schedule should include the salaries of the staff employed by the agency that work in the program covered in this cost report.
- Accrued is a limited and specific accounting term – mostly it is used to cover a payroll that crosses over the end of an accounting period.

- If employee is allocated among multiple programs and multiple cost reports include the %FTE for this program and only and % salary matching.
- If employee is part time record % FTE worked and enter total salary annualized to calculate correct program cost.
- For all FTE less the 100% note in allocation basis either that employee is part time to agency or allocation based employee time worked in program
- Time in program allocation must have internal documentation supporting allocation.

- For personal services not paid as salary
- Contract nurses for example if charged directly to the program report in column 2
- Accountants and auditors etc whose costs are shared among programs report in column 3
- Payments to foster parents on line 1 in column 2.

Contract/Consultant Con’td

- Line B is place to record indirect agency overhead costs to a program cost center report – this is only if not already included in the line item expenses
- All costs reported in line B need to be described on Attachment A

Consumable pg 4

- Record consumable line item costs as indicated – aggregate as needed, retain workpapers
- NOTE there is no “Miscellaneous” line item and any amount in the Other category must be described – this is not a mistake we need to know if an expense is allowable for federal claiming

- Schedules are provided for occupancy, travel, and equipment to separate allowable and unallowable portions of these expenses

Revenue Sources pg 6

- The revenue sources and the amounts received for the programs are important. USDA and other federal revenue are treated as an offset to costs.
- Total Revenues should equal or only modestly vary from total program costs; explain if they do not.

Audit Reconcilation

- It is expected that your reported costs will tie back to the agency audit – if not please explain variances in space provided
- For programs that are part of a larger agency please reference a program cost detail schedule from the audit

Description of Allowable costs

- Please note beginning on page 10 of the instructions the detail descriptions of allowable costs by line item
- Note also the Unallowable costs detail on page 12

Questions?
Contact us:

- Richard O’Neill @ DHR
raoniell@dhr.state.ga.us

- Phillip Sewell
phillipsewell@djj.state.ga.us

- Mary Willoughby, consultant
marywilloughby@bellsouth.net