CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Provider Information			
PPS METHODOLOGY:				
This box for state use only - LEAVE BLANK				
Select type of oversight:		Audited		Desk Reviewed
Date reviewed:				

PART 1 - PROVIDER INFORMATION (Consolidated)				
1.	Name:			
2.	Street:		P.O. Box:	
3.	City:	State:	Zip Code:	
4.	County:			
5.	Medicaid ID:			
6.	NPI:			
7.	Location designation (see Cost Report Instructions):			
8.	Organizational authority (see Cost Report Instructions):			
9.	Behavioral health professionals (see Cost Report Instructions):			

	Name 1	NPI 2
9a		
9b		
9c		
9d		
9e		

10.	Is the CCBHC dually certified as a 1905(a)(9) clinic?	
11.	Does the site operate as other than CCBHC?	
12.	If line 11 is "Yes" specify the type of operation (e.g., clinic, FQHC, other):	
13.	Identify days and hours the site operates as a CCBHC by listing the time next to the applicable day:	

	Days	Hours of Operation From	Hours of Operation To	Total Hours
13a	Sunday			
13b	Monday			
13c	Tuesday			
13d	Wednesday			
13e	Thursday			
13f	Friday			
13g	Saturday			

14.	Identify days and hours the site operates as other than a CCBHC by listing the time next to the applicable day:	

	Days	Hours of Operation From	Hours of Operation To	Total Hours
14a	Sunday			
14b	Monday			
14c	Tuesday			
14d	Wednesday			
14e	Thursday			
14f	Friday			
14g	Saturday			

15	List any excluded satellite facilities and reasons for exclusion. Use the Comments Sheet for additional details.	
16.	Is this site filing a consolidated cost report for multiple locations? If yes, see Cost Report Instructions.	
17.	How many sites are reported for the consolidated entity?	

CCBHC Cost Report			
MEDICAID ID:			
NPI:			
REPORTING PERIOD:	From:	To:	

PART 2 - PROVIDER INFORMATION FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING (For additional satellite sites, create new tab and copy and paste Part 2 for each additional site included)				
Site-Specific Information				
1.	Was this site in existence before April 1, 2014? (No payment will be made to satellite facilities of CCBHCs established after April 1, 2014).			
2.	Name:			
3.	Street:	P.O. Box:		
4.	City: State:	Zip Code:		
5.	County:			
6.	Medicaid ID:			
7.	NPI:			
8.	Location designation (see Cost Report Instructions):			
9.	Organizational authority (see Cost Report Instructions):			
10.	Is the CCBHC dually certified as a 1905(a)(9) clinic?			
11.	Does the site operate as other than CCBHC?			
12.	If line 11 is "Yes", specify the type of operation (e.g., clinic, FQHC, other):			
13.	Identify days and hours the site operates as a CCBHC by listing the time next to the applicable day			
	Days	Hours of Operation From	Hours of Operation To	Total Hours
13a	Sunday			
13b	Monday			
13c	Tuesday			
13d	Wednesday			
13e	Thursday			
13f	Friday			
13g	Saturday			
14.	Identify days and hours the site operates as other than a CCBHC by listing the time next to the applicable day			
	Days	Hours of Operation From	Hours of Operation To	Total Hours
14a	Sunday			
14b	Monday			
14c	Tuesday			
14d	Wednesday			
14e	Thursday			
14f	Friday			
14g	Saturday			

CCBHC Cost Report

MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Trial Balance			

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
1.	Psychiatrist			$0		$0		$0		$0
2.	Psychiatric nurse			$0		$0		$0		$0
3.	Child psychiatrist			$0		$0		$0		$0
4.	Adolescent psychiatrist			$0		$0		$0		$0
5.	Substance abuse specialist			$0		$0		$0		$0
6.	Case manager			$0		$0		$0		$0
7.	Recovery coach			$0		$0		$0		$0
8.	Peer specialist			$0		$0		$0		$0
9.	Family support specialist			$0		$0		$0		$0
10.	Licensed clinical social worker			$0		$0		$0		$0
11.	Licensed mental health counselor			$0		$0		$0		$0
12.	Mental health professional (trained and credentialed for psychological testing)			$0		$0		$0		$0
13.	Licensed marriage and family therapist			$0		$0		$0		$0
14.	Occupational therapist			$0		$0		$0		$0
15.	Interpreter or linguistic counselor			$0		$0		$0		$0
16.	General practice (performing CCBHC services)			$0		$0		$0		$0
17.	Other staff costs (specify details below)									
17a				$0		$0		$0		$0
18.	Subtotal staff costs (sum of lines 1-17)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

PART 1B - CCBHC COSTS UNDER AGREEMENT

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
19.	CCBHC costs from DCO			$0		$0		$0		$0
20.	Other CCBHC costs (specify details below)									
20a				$0		$0		$0		$0
21.	Subtotal costs under agreement (sum of lines 19-20)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	

PART 1C - OTHER DIRECT CCBHC COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
22.	Medical supplies			$0		$0		$0		$0
23.	Transportation (health care staff)			$0		$0		$0		$0
24.	Depreciation - medical equipment			$0		$0		$0		$0
25.	Professional liability insurance			$0		$0		$0		$0
26.	Telehealth			$0		$0		$0		$0
27.	Other direct costs not already included (specify details below)									
27a				$0		$0		$0		$0
28.	Subtotal other direct CCBHC costs (sum of lines 22-27)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
29.	**Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

CCBHC Cost Report

MEDICAID ID:			
NPI:			
REPORTING PERIOD:	From:	To:	

PART 2 - INDIRECT COSTS

PART 2A - SITE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
30.	Rent			$0		$0		$0		$0
31.	Insurance			$0		$0		$0		$0
32.	Interest on mortgage or loans			$0		$0		$0		$0
33.	Utilities			$0		$0		$0		$0
34.	Depreciation - buildings and fixtures			$0		$0		$0		$0
35.	Depreciation - equipment			$0		$0		$0		$0
36.	Housekeeping and maintenance			$0		$0		$0		$0
37.	Property tax			$0		$0		$0		$0
38.	Other site costs (specify details below)									
38a				$0		$0		$0		$0
39.	Subtotal site costs (sum of lines 30-38)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

PART 2B - ADMINISTRATIVE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
40.	Office salaries			$0		$0		$0		$0
41.	Depreciation - office equipment			$0		$0		$0		$0
42.	Office supplies			$0		$0		$0		$0
43.	Legal			$0		$0		$0		$0
44.	Accounting			$0		$0		$0		$0
45.	Insurance			$0		$0		$0		$0
46.	Telephone			$0		$0		$0		$0
47.	Other administrative costs (specify details below)									
47a				$0		$0		$0		$0
48.	Subtotal administrative costs (sum of lines 40-47)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
49.	**Total overhead (sum of lines 39 and 48)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

CCBHC Cost Report

MEDICAID ID:			
NPI:			
REPORTING PERIOD:	From:	To:	

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
50.	Direct costs for non-CCBHC services covered by Medicaid (specify details below)									
50a				$0		$0		$0		$0

PART 3B - NON-REIMBURSABLE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
51.	Direct costs for non-CCBHC services *not* covered by Medicaid (specify details below)									
51a				$0		$0		$0		$0
52.	Total costs for non-CCBHC services (sum of lines 50-51)	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
53.	**Total costs (sum of lines 29, 49, and 52)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Trial Balance Reclassifications			

Explanation of Entry		**Increase:** Expense Category 1	**Increase:** Line Number 2	**Increase:** Amount* 3	**Decrease:** Expense Category 4	**Decrease:** Line Number 5	**Decrease:** Amount* 6
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							
16.							
17.							
18.							
19.							
20.							
21.							
22.							
23.							
24.							
25.							
26.							
27.							
28.							
29.							
30.							
31.							
32.							
33.							
34.							
35a							
36.	Total reclassifications (sum of column 3 must equal sum of column 6)			$ -			$ -

* Transfer to Trial Balance worksheet, column 4 as appropriate

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Trial Balance Adjustments			

PART 1 - COMMON ADJUSTMENTS					
	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
1.	Investment income on commingled restricted and unrestricted funds				
2.	Trade, quantity, and time discounts on purchases				
3.	Rebates and refunds of expenses				
4.	Rental of building or office space to others				
5.	Home office costs				
6.	Adjustment resulting from transactions with related organizations				
7.	Vending machines				
8.	Practitioner assigned by National Health Service Corps				
9.	Depreciation - buildings and fixtures				
10.	Depreciation - equipment				
11.	Other common adjustments (specify details below)				
11a					
12.	Subtotal of common adjustments (sum of lines 1-11)		$0		

PART 2 - COSTS NOT ALLOWED (Must be removed from allowable costs)					
	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
13.	Bad debts	A			
14.	Charitable contributions	A			
15.	Entertainment costs, including costs of alcoholic beverages	A			
16.	Federal, state, or local sanctions or fines	A			
17.	Fund-raising costs	A			
18.	Goodwill, organization costs, or other amortization	A			
19.	Legal fees related to criminal investigations	A			
20.	Lobbying costs	A			
21.	Selling and marketing costs	A			
22.	Subtotal of other costs not allowed (specify details below)				
22a		A			
23.	Subtotal of costs not allowed (sum of lines 13-22)	A	$0		
24.	Total Adjustments (sum of lines 12 and 23)		$0		

*Basis for adjustment
A. Costs - if cost (including applicable overhead) can be determined
B. Amount received - if cost cannot be determined

** Transfer to Trial Balance worksheet, column 6 as appropriate

*** Expense classification on Trial Balance worksheet from which amount is to be deducted or to which the amount is to be added

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Anticipated Costs			

PART 1 - DIRECT CCBHC EXPENSES					
PART 1A - CCBHC STAFF COSTS					
	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
1.	Psychiatrist				$0
2.	Psychiatric nurse				$0
3.	Child psychiatrist				$0
4.	Adolescent psychiatrist				$0
5.	Substance abuse specialist				$0
6.	Case manager				$0
7.	Recovery coach				$0
8.	Peer specialist				$0
9.	Family support specialist				$0
10.	Licensed clinical social worker				$0
11.	Licensed mental health counselor				$0
12.	Mental health professional (trained and credentialed for psychological testing)				$0
13.	Licensed marriage and family therapist				$0
14.	Occupational therapist				$0
15.	Interpreters or linguistic counselor				$0
16.	General practice (performing CCBHC services)				$0
17.	Other staff costs (specify details below)				
17a					$0
	Additional lines inserted via Trial Balance tab				
18.	Subtotal staff costs (sum of lines 1-17)	0	$0	$0	$0

PART 1B - CCBHC COSTS UNDER AGREEMENT					
	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
19.	CCBHC costs from DCO				$0
20.	Other CCBHC costs (specify details below)				
20a					$0
	Additional lines inserted via Trial Balance tab				
21.	Subtotal costs under agreement (sum of lines 19-20)		$0	$0	$0

PART 1C - OTHER DIRECT CCBHC COSTS					
	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
22.	Medical supplies				$0
23.	Transportation (health care staff)				$0
24.	Depreciation - medical equipment				$0
25.	Professional liability insurance				$0
26.	Telehealth				$0
27.	Other direct costs not already included (specify details below)				
27a					$0
	Additional lines inserted via Trial Balance tab				
28.	Subtotal other direct CCBHC costs (sum of lines 22-27)		$0	$0	$0
29.	**Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28)**	$0	$0	$0	$0

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Anticipated Costs			

PART 2 - INDIRECT COSTS					
PART 2A - SITE COSTS					
	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
30.	Rent				$0
31.	Insurance				$0
32.	Interest on mortgage or loans				$0
33.	Utilities				$0
34.	Depreciation - buildings and fixtures				$0
35.	Depreciation - equipment				$0
36.	Housekeeping and maintenance				$0
37.	Property tax				$0
38.	Other site costs (specify details below)				
38a					$0
	Additional lines inserted via Trial Balance tab				
39.	Subtotal site costs (sum of lines 30-38)		$0	$0	$0

PART 2B - ADMINISTRATIVE COSTS					
	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
40.	Office salaries				$0
41.	Depreciation - office equipment				$0
42.	Office supplies				$0
43.	Legal				$0
44.	Accounting				$0
45.	Insurance				$0
46.	Telephone				$0
47.	Other administrative costs (specify details below)				
47a					$0
	Additional lines inserted via Trial Balance tab				
48.	Subtotal administrative costs (sum of lines 40-47)		$0	$0	$0
49.	**Total overhead (sum of lines 39 and 48)**		$0	$0	$0

CCBHC Cost Report

MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Anticipated Costs			

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

Description	Additional Required Full-Time Equivalent (FTE) Staff	Additional Expense Amount	Reduced Expense Amount	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3)
	1	2	3	4
50. Direct costs for non-CCBHC services covered by Medicaid (specify details below)				
50a				**$0**
Additional lines inserted via Trial Balance tab				

PART 3B - NON-REIMBURSABLE COSTS

Description	Additional Required Full-Time Equivalent (FTE) Staff	Additional Expense Amount	Reduced Expense Amount	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3)
	1	2	3	4
51. Direct costs for non-CCBHC services *not* covered by Medicaid (specify details below)				
51a				**$0**
Additional lines inserted via Trial Balance tab				
52. Subtotal costs for non-CCBHC services (sum of 50-51)		**$0**	**$0**	**$0**
53. Total costs (sum of lines 29, 49, and 52)	**0**	**$0**	**$0**	**$0**

* Transfer to Trial Balance worksheet, column 8 as appropriate

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Indirect Cost Allocation			

	Description	
1.	Does the CCBHC have a indirect cost rate approved by a cognizant agency (see Cost Report Instructions)? If no, go to line 7.	
2.	Which cognizant agency approved the rate?	
3.	Describe the base rate with respect to the indirect cost rate.	
4.	Enter the basis amount subject to the rate agreement	
5.	Enter the approved rate amount	
6.	Calculated indirect costs allocable to CCBHC services (line 4 multiplied by line 5)	**$0**
7.	Does the CCBHC qualify to use the federal minimum rate and elect to use the rate for all federal awards? See instructions for qualifications. If no, go to line 11.	
8.	Direct costs for CCBHC services (Trial Balance, column 9, line 29)	**$0**
9.	Minimum rate	**10.0%**
10.	Calculated indirect costs allocable to CCBHC services (line 8 multiplied by line 9)	**$0**
11.	Will the CCBHC allocate indirect costs proportionally by the percentage of direct costs for CCBHC services versus total allowable costs less indirect costs? If no, go to line 15.	
12.	Percentage of direct costs versus total allowable direct costs (Trial Balance, column 9, line 29 divided by the sum of Trial Balance, column 9, line 29 and Trial Balance, column 9, line 52)	**0.0%**
13.	Indirect costs to be allocated (Trial Balance, column 9, line 49)	**$0**
14.	Calculated indirect costs allocable to CCBHC services (line 12 multiplied by line 13)	**$0**
15.	If none of the lines 1, 7, or 11 are entered as Yes, provide a thorough description of the cost allocation method used. Include attachments for descriptions and calculations. Include references to line items included in the Trial Balance tab. Enter the amount of indirect costs allocated to providing CCBHC services here.	
16.	Total indirect costs allocated to CCBHC services	**$0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Allocation Descriptions			

PLEASE EXPLAIN METHODS USED FOR ALLOCATING RESOURCES TO DIRECT OR INDIRECT COSTS
Justification for allocation:

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Daily Visits			

PATIENT DEMOGRAPHICS CONSOLIDATED		
	Include ALL visits for CCBHC services; do not limit it to those covered by Medicaid.	Patient Visits 1
1.	Number of daily visits for patients receiving CCBHC services provided directly from staff	
2.	Number of daily visits for patients receiving CCBHC services directly from DCO (not included above)	
3.	Number of additional anticipated daily visits for patients receiving CCBHC services	
4.	Total daily visits for patients receiving CCBHC services (sum of lines 1-3)	**0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Monthly Visits			

PATIENT DEMOGRAPHICS CONSOLIDATED

Patient demographics should be analyzed to identify Certain Conditions. Because CC PPS-2 requires monthly detail, patient data must be aggregated by patient by month to determine eligibility for Certain Conditions. Months should be captured for ALL CCBHC services provided; do not limit the information to Medicaid members.

Description	Standard Population Visit Months All 1a	Standard Population Visit Months Above the Outlier Threshold 1b	Certain Conditions 1 Visit Months All 2a	Certain Conditions 1 Visit Months Above the Outlier Threshold 2b	Certain Conditions 2 Visit Months All 3a	Certain Conditions 2 Visit Months Above the Outlier Threshold 3b		Monthly Patient Visit (Sum of col. a's) Total
1. Describe population								
2. Number of months patients received CCBHC services directly from staff								0
3. Number of months patients received CCBHC services directly from DCO (not included above)								0
4. Number of additional anticipated months patients received CCBHC services (not included above)								0
5. Total months patients received CCBHC services (sum of lines 2-4)	**0**	**0**	**0**	**0**	**0**	**0**		**0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Services Provided			

PART 1 - SERVICES PROVIDED (Consolidated)					
PART 1A - CCBHC STAFF SERVICES					
	Description	Number of Full-Time Equivalent (FTE) Staff	Total Number of Services Provided for CCBHC Services	Direct Cost (from Trial Balance, Col. 9)	Average Cost per Service by Position (Col. 3 divided by Col. 2)
		1	2	3	4
1.	Psychiatrist			$ -	$ -
2.	Psychiatric nurse			$ -	$ -
3.	Child psychiatrist			$ -	$ -
4.	Adolescent psychiatrist			$ -	$ -
5.	Substance abuse specialist			$ -	$ -
6.	Case manager			$ -	$ -
7.	Recovery coach			$ -	$ -
8.	Peer specialist			$ -	$ -
9.	Family support specialist			$ -	$ -
10.	Licensed clinical social worker			$ -	$ -
11.	Licensed mental health counselor			$ -	$ -
12.	Mental health professional (trained and credentialed for psychological testing)			$ -	$ -
13.	Licensed marriage and family therapist			$ -	$ -
14.	Occupational therapist			$ -	$ -
15.	Interpreters or linguistic counselor			$ -	$ -
16.	General practice (performing CCBHC services)			$ -	$ -
17.	Other staff services (specify details below)				
17a				$ -	$ -
	Additional lines inserted via Trial Balance tab				
18.	Subtotal staff services (sum of lines 1-17)	**0**	**0**	$ -	$ -

PART 1B - CCBHC SERVICES UNDER AGREEMENT					
	Description	Number of Full-Time Equivalent (FTE) Staff	Total Number of Services Provided for CCBHC Services	Direct Cost (from Trial Balance, Col. 9)	Average Cost per Service by Position (Col. 3 divided by Col. 2)
		1	2	3	4
19.	CCBHC services from DCO			$ -	$ -
20.	Other CCBHC services (specify details below)				
20a				$ -	$ -
	Additional lines inserted via Trial Balance tab				
21.	Subtotal services under agreement (sum of lines 19-20)		**0**	$ -	$ -
22.	**Total services (sum of lines 18 and 21)**	**0**	**0**	$ -	$ -

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Services Provided			

PART 2 - SERVICES PROVIDED BY SITE (For additional satellite sites, create new tab and copy and paste Part 2 for each additional site included)

PART 2A - CCBHC STAFF SERVICES

	Description	Number of Full-Time Equivalent (FTE) Staff 1	Total Number of Services Provided for CCBHC Services 2
1.	Psychiatrist		
2.	Psychiatric nurse		
3.	Child psychiatrist		
4.	Adolescent psychiatrist		
4.	Adolescent psychiatrisu		
5.	Substance abuse specialist		
6.	Case manager		
7.	Recovery coach		
8.	Peer specialist		
9.	Family support specialist		
10.	Licensed clinical social worker		
11.	Licensed mental health counselor		
12.	Mental health professional (trained and credentialed for psychological testing)		
13.	Licensed marriage and family therapist		
14.	Occupational therapist		
15.	Interpreters or linguistic counselor		
16.	General practice (performing CCBHC services)		
17.	Other staff services (specify details below)		
17a			
	Additional lines inserted via Trial Balance tab		
18.	Subtotal staff services (sum of lines 1-17)	**0**	**0**

PART 2B - CCBHC SERVICES UNDER AGREEMENT

	Description	Number of Full-Time Equivalent (FTE) Staff 1	Total Number of Services Provided for CCBHC Services 2
19.	CCBHC services from DCO		
20.	Other CCBHC services (specify details below)		
20a			
	Additional lines inserted via Trial Balance tab		
21.	Subtotal services under agreement (sum of lines 19-20)		**0**
22.	**Total services (sum of lines 18 and 21)**	**0**	**0**

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Services Provided			

OMB #0398-1148 CMS-10398 (#43)
End of Worksheet

CCBHC Cost Report

MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Comments			

Please explain or comment on any additional considerations that should be taken into account in determining the appropriate payment rate

Worksheet	Line	Comment 1	Comment 2	Comment 3	Comment 4	Comment 5	Comment 6	Comment 7	Comment 8	Comment 9

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	CC PPS-1 Rate			

PART 1 - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC		
	Description	Amount 1
1.	Total direct cost of CCBHC services (Trial Balance, column 9, line 29)	**$0**
2.	Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16)	**$0**
3.	Total allowable CCBHC costs (sum of lines 1-2)	**$0**

PART 2 - DETERMINATION OF CC PPS-1 RATE		
	Description	Amount 1
4.	Total allowable CCBHC costs (line 3)	**$0**
5.	Total CCBHC visits* (Daily Visits, column 1, line 4)	**0**
6.	Unadjusted PPS rate (line 4 divided by line 5)	**$0**
7.	Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period	**0.000%**
8.	CC PPS-1 rate (line 6 adjusted by factor from line 7)	**$0**
* Total should reflect the total count of CCBHC visits provided and not be restricted to Medicaid visits		

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	CC PPS-2 Rate			

PART 1 - COST-TO-CHARGE RATIO ALLOCATION									
	Description	Standard Population Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 1a	Standard Population Charges and Costs for CCBHC Services: Above the Outlier Threshold 1b	Certain Conditions 1 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 2a	Certain Conditions 1 Charges and Costs for CCBHC Services: Above the Outlier Threshold 2b	Certain Conditions 2 Charges and Costs for CCBHC Services: At or Below the Outlier Threshold 3a	Certain Conditions 2 Charges and Costs for CCBHC Services: Above the Outlier Threshold 3b	Additional columns inserted via Monthly Visits tab	Total Population Charges and Costs (Sum of all Columns) Total
1.	Actual charges								$0
2.	Anticipated additional charges (DY1 only)								$0
3.	Total charges (sum of lines 1-2)	$0	$0	$0	$0	$0	$0		$0
4.	Total direct costs (Trial Balance, column 9, line 29)								$0
5.	Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16)								$0
6.	Total allowable costs for CCBHC services (sum of lines 4-5)								$0
7.	Cost-to-charge ratio services (line 6 divided by line 3)								0%
8.	**Total cost of CCBHC services (line 3 times line 7)**	$0	$0	$0	$0	$0	$0		$0
	Cross Check: Total costs should tie to the total direct and indirect costs applicable to CCBHC services							Difference	$0

PART 2 - DETERMINATION OF CC PPS-2 RATE									
	Description	Standard Population Costs for CCBHC Services: At or Below the Outlier Threshold 1a	Standard Population Costs for CCBHC Services: Above the Outlier Threshold 1b	Certain Conditions 1 Costs for CCBHC Services: At or Below the Outlier Threshold 2a	Certain Conditions 1 Costs for CCBHC Services: Above the Outlier Threshold 2b	Certain Conditions 2 Costs for CCBHC Services: At or Below the Outlier Threshold 3a	Certain Conditions 2 Costs for CCBHC Services: Above the Outlier Threshold 3b	Additional columns inserted via Monthly Visits tab	Total Population Costs (Sum of all Columns) Total
9.	Total allowable CCBHC costs (line 8)	$0	$0	$0	$0	$0	$0		$0
10.	Total months patients received CCBHC services (Monthly Visits, line 5)*	0		0		0			0
11.	Total allowable cost per visit (line 9 divided by line 10)	$0		$0		$0			$0
12.	Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period								0.000%
13.	CC PPS-2 rate (line 11 adjusted by factor from column Total, line 12)	$0		$0		$0			$0
14.	Outlier pool (line 9)		$0		$0		$0		$0
* Column "a" reflects the count for All visits. The total reflects the sum of "a" columns.									

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Certification			

MEDICAID COST REPORT

for Certified Community Behavioral Health Clinics

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINE; AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED DIRECTLY OR INDIRECTLY THROUGH THE PAYMENT OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINES; AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR IS REQUIRED.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and that to the best of my knowledge and belief, this report and statement are true, correct, complete, and prepared from the books and records of the Provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the cost report were provided in compliance with such laws and regulations.

Signature of Officer:	
Title:	
Clinic:	
Medicaid ID:	
From Period:	
To Period:	
Preparer (If other than Officer):	