Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 96—Medicaid Primary and Prenatal Care Clinic Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 96—Medicaid Primary and Prenatal Care Clinic Program

13 CSR 70-96.010 Reimbursement for Medicaid Primary and Prenatal Care Clinic Program

PURPOSE: This rule establishes the regulatory basis for Title XIX Medicaid payment for Primary and Prenatal Care Clinic Program services.

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate rules.

(2) Qualification. For a clinic to qualify for participation in the Medicaid Primary and Prenatal Care Clinic (PPCC) program, the clinic must meet all of the following criteria:

(A) Must be owned and operated by the Department of Social Services;

(B) Provide services to county residents with incomes below two hundred percent (200%) of the federal poverty level on a sliding fee scale basis, regardless of ability to pay for the services;

(C) Provide on-site, or have firm financial arrangements, for diagnostic laboratory, radiologic services and pharmacy services; and

(D) Provide social services to patients to assist with meeting psychosocial, behavioral and environmental needs, through linkages with community resources and collaborative activities regarding public health issues with the local health departments.

(3) General Principles.

(A) The Missouri Medical Assistance (Medicaid) program shall reimburse PPCC providers based on the reasonable cost of PPCC-covered services related to the care of Medicaid recipients (within program limitations) less any copayment or other third-party liability amounts which may be due from Medicaid recipients effective for services on and after February 2, 1994.

(B) Reasonable costs shall be determined by the Division of Medical Services based on desk review of the applicable cost reports and shall be subject to adjustment based on field audit. Reasonable costs shall not exceed the Medicare cost principles set forth in 42 CFR part 413.

(C) Reasonable costs shall be apportioned to the Medicaid program based on a ratio of covered charges for beneficiaries to total charges. Charges mean the regular rate for various services which are established uniformly for Medicaid recipients and other patients.

(4) Definitions.

(A) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(B) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(C) Effective date.

1. The rule effective date shall be February 2, 1994.

(D) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period.

(E) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.

(F) Provider or facility. A PPCC with a valid Medicaid participation agreement in effect on or after February 2, 1994, with the Department of Social Services for the purpose of providing PPCC services to Title XIX-eligible recipients.

(5) Administrative Actions.

(A) Annual Cost Report.

1. Each PPCC shall complete a Medicaid cost report for the PPCC's twelve (12)-month fiscal period.

2. Each PPCC is required to complete and submit to the division an Annual Cost Report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report shall be submitted within three (3) calendar months after the close of the reporting period. A single extension, not to exceed thirty (30) days, may be granted upon the request of the PPCC and the approval of the division. The request must be received in writing by the division prior to the ninetieth day of the three (3) calendar-month period after the close of the reporting period.

5. In a change of ownership, the cost report for the closing period must be submitted within forty-five (45) calendar days of the effective date of the change of ownership, unless the change in ownership coincides with the seller's fiscal year end, in which case the cost report must be submitted within three (3) months after the close of the reporting period. No extensions in the submitting of cost reports shall be granted when a change in ownership has occurred.

6. Cost reports shall be submitted and certified by an officer or administrator of the provider. Failure to file a cost report within the prescribed period, except as expressly extended in writing by the state agency, may result in the imposition of sanctions as described in 13 CSR 70-3.030.

7. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter;

B. Contracts or agreements involving the purchase of facilities or equipment during the five (5) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Schedule detailing all grants, gifts and income from endowments, including: amounts, restrictions and use;

F. Documentation of expenditures, by line item, made under all restricted and unrestricted grants, gifts or endowments;

G. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

H. Leases or rental agreements, or both, related to the activities of the provider;

I. Management contracts;

J. Provider of service contracts; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Under no circumstance will the division accept amended cost reports for final settlement determination or adjustment after

the date of the division's notification of the final settlement amount.

(B) Records.

1. Maintenance and availability of records.

A. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

B. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

C. Records of related organization, as defined by 42 CFR 413.17, must be available upon demand.

D. The division shall retain all uniform cost reports submitted for a period of at least three (3) years following the date of submission of the reports and will maintain those reports pursuant to the recordkeeping requirements of 42 CFR 413.20.

E. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than five (5) years.

2. Adequacy of records.

A. The division may suspend reimbursement or reduce payments to the appropriate fee schedule amounts if it determines that the PPCC does not maintain records that provide an adequate basis to determine payments under Medicaid.

B. The suspension or reduction continues until the PPCC demonstrates to the division's satisfaction that it does, and will continue to, maintain adequate records.

(C) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

(D) Change in Provider Status. The next payment due the provider after the division has received the notification of the termination of participation in the Medicaid program or change of ownership may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(6) Nonallowable Costs. Cost not reasonably related to PPCC services shall not be included in a provider's costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Bad debts, charity and courtesy allowances;

(B) Return on equity capital;

(C) Capital cost increases due solely to changes in ownership;

(D) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, but excluding organizational costs;

(E) Attorney fees related to litigation involving state, local or federal governmental entities and attorney's fees which are not related to the provision of PPCC services, such as litigation related to disputes between or among owners, operators or administrators;

(F) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(G) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program;

(H) Late charges and penalties;

(I) Finder's fees;

(J) Fund-raising expenses;

(K) Interest expense on intangible assets;

(L) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(M) Research costs;

(N) Salaries, wages or fees paid to nonworking officers, employees or consultants; and

(O) Costs of services performed in a satellite clinic, which does not have a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing PPCC services to Title XIX-eligible recipients.

(7) Interim Payments. Effective for services provided on or after February 2, 1994, PPCC services, unless otherwise limited by rule, shall be reimbursed on an interim basis by Medicaid at ninety-five percent (95%) of usual and customary charges as billed by the provider for covered PPCC services. Interim payments shall be reduced by copayments and other third-party liabilities.

(8) Reconciliation.

(A) The state agency shall perform an annual desk review of the Medicaid cost reports for each PPCC's fiscal year and shall make indicated adjustments of additional payment or recoupment, in order that the PPCC's net reimbursement shall be in amounts representing one hundred percent (100%) of reasonable costs.

(B) Notice of Program Reimbursement. The division shall send written notice to the PPCC of the following:

1. Underpayments. If the total reimbursement due the PPCC exceeds the interim payments made for the reporting period, the division makes a lump-sum payment to the PPCC to bring total interim payments into agreement with total reimbursement due the PPCC.

2. Overpayments. If the total interim payments made to a PPCC for the reporting period exceed the total reimbursement due the PPCC for the period, the division arranges with the PPCC for repayment through a lump sum refund or, if that poses a hardship for the PPCC, through offset against subsequent interim payments or a combination of offset and refund.

(C) The annual desk review will be subject to adjustment based on the results of a field audit which may be conducted by the division or its contracted agents.

(9) Sanctions.

(A) The division may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(10) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(11) Payment Assurance.

(A) The state will pay each PPCC, which furnishes the services in accordance with the requirements of the state plan, the amount determined for services furnished by the PPCC according to the standards and methods set forth in the rules implementing the PPCC Reimbursement Program.

(B) PPCC services provided for those recipients having available Medicare benefits shall be reimbursed by Medicaid to the extent of the coinsurance and deductible as imposed under Title XVIII.

(C) Where third-party payment is involved, Medicaid will be the payor of last resort.

(D) Regardless of changes of ownership, management, control, leasehold interests by whatever form for any PPCC previously certified for participation in the Medicaid program, the division will continue to make all the Title XIX payments directly to the entity with the PPCC's current provider number and hold the entity with the current provider number responsible for all Medicaid liabilities.

(12) Payment in Full. Participation in the Medicaid program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable copayments.

AUTHORITY: section 208.201, RSMo Supp. 1987. Emergency rule filed Jan. 14, 1994, effective Feb. 2, 1994, expired June 1, 1994. Emergency rule filed May 23, 1994, effective June 2, 1994, expired Sept. 29, 1994. Emergency amendment filed June 21, 1995, effective July 1, 1995, expired Oct. 28, 1995. Original rule filed Jan. 14, 1994, effective Aug. 28, 1994.*

**Original authority: 208.201, RSMo 1987.*

WORKSHEET INSTRUCTIONS
FOR
PRIMARY AND PRENATAL CARE CLINIC
TITLE XIX COST REPORT

STATISTICAL DATA

Item 1: **CLINIC NAME AND ADDRESS.** Enter here the full name and address of the PPCC.

Item 2: **CLINIC NUMBER.** Enter the PPCC identification number that was provided by the Division when the clinic entered the program.

Item 3: **REPORTING PERIOD.** Enter the inclusive dates covered by this cost report.

Item 4: **TYPE OF CONTROL.** Indicate by checking the type of ownership under which the facility is operated.
Check only one.

Item 5: **PPCC OWNED BY.** The facility must be owned by the Missouri Department of Social Services in order to become a PPCC.

Item 6: **RELATED ORGANIZATIONS.** List all clinics, providers of services, (hospitals, nursing facilities, home health agencies) suppliers or other entities that are owned, or related through common ownership or control, to the individual.

Item 7: **PERFORMING PROVIDERS FURNISHING SERVICES AT PPCC.** List all performing providers furnishing services at the PPCC or under agreements and their Medicaid performing provider numbers.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC. This certification must be prepared and signed after the cost report has been completed in its entirety. The individual signing must be an officer or other authorized responsible person.

PREPARER OF REPORT. Enter the name and telephone number of the person who prepared the report in case further information or clarification of the report is required.

WORKSHEETS

WORKSHEET 1 - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

General Instructions

This worksheet provides for recording the trial balance of expense accounts from the PPCC's accounting books and records. The worksheet also provides for any necessary reclassification and adjustments to these accounts.

Not all of the listed cost centers will apply to each PPCC. For example, a PPCC might not employ radiology technicians and would not, in that case, complete line 10. The worksheet also provides blank lines for clinic costs and cost centers in addition to those listed in the form. If the worksheet does not provide sufficient space, enter aggregate amounts on Worksheet 1 under "other," where appropriate, and furnish a supporting schedule to list items included in the aggregate amounts.

Columns 1 through 3 - TRIAL BALANCES OF DIRECT EXPENSES
The expenses listed in these columns must be in accordance with the PPCC's accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. The expenses must be detailed between compensation (column 1), and other than compensation and related costs (column 2). For example, payroll taxes, employee benefits, and workers' compensation

should be reported in column 2 on the appropriate salary line for which these expenses pertain to. The sum of columns 1 and 2 must equal column 3. Any needed reclassifications and adjustments must be recorded in column 4 and 6, as appropiate.

Column 4 - RECLASSIFICATION
This column is used to reclassify expenses among the cost centers for proper grouping of expenses. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on the worksheet are maintained in the PPCC's accounting books and records in one cost center. For example, if a physician performs some administrative duties, the appropriate portion of his compensation, and applicable payroll taxes and fringe benefits, would need to be reclassified from "Health Care Staff Cost" to "Overhead Costs- Administrative Cost." Reduction to expenses should be shown in brackets [ ].

Worksheet 1-A is provided to compute the reclassification affecting the expenses specified therein. This worksheet need not be completed by all facilities but must be completed only to the extent that the reclassifications are needed and appropriate in the facility's circumstances.

The net total of the entries in column 4 must equal zero on line 92.

Column 5 - RECLASSIFIED TRIAL BALANCE
This column is the sum of columns 3 and 4. The net balance for each line is entered in column 5. The total of column 5 on line 92 must equal the total of column 3 on line 92.

Column 6 - ADJUSTMENTS
This column is used to indicate the amount of any adjustments to the PPCC's reclassified expenses. Adjustments may be required to increase or decrease expenses in accordance with the Medicaid rules on allowable costs. Some examples of situations in which adjustments to expenses would be required are:

1. the PPCC has transactions with a related party;
2. the PPCC depreciates assets on other than an acceptable basis, recognized by Medicaid;
3. the PPCC reports bad debts expense.

Decreases to expenses are shown in brackets [ ].

All adjustments in column 6 of Worksheet 1, must be entered on Worksheet 1-B.

Column 7 - NET EXPENSES
This column is the sum of columns 5 and 6: The net balance of each line item is entered in colum 7.

LINE DESCRIPTION

Lines 1 - 21 - Combined Health Care Staff Costs
On lines 2 through 21, the costs of the PPCC's health care staff are entered by type of staff.

Line 22 - Subtotal-Combined Health Care Staff Costs
Record total of lines 2 through 21. Line 22, column 7 is transferred to W/S 3, line A-1.

Lines 24 - 33 - Other Combined Health Care Costs
Enter on these lines the costs directly related to the delivery of medical and other health care services. Include only those items **directly related to patient care** which have not been included in any other cost center. The following costs should be excluded: costs of overhead; cost of health care staff reported elsewhere.

Line 34 - Subtotal-Other Combined Health Care Costs
Record total of lines 25 through 33. Line 34, column 7 is transferred to W/S 3, line A-2.

Lines 36 - 41 - Clinical Social Worker/Psychologist Costs
Enter on lines 37 through 41, the costs directly related to the delivery of clinical social worker and psychologist services.

Line 42 - Subtotal-Clinical Social Worker/Psychologist Costs
Record total of lines 37 through 41. Line 42, column 7 is transferred to W/S 3, line A-4.

Lines 44 - 47 - Case Management Costs
Enter on lines 45 through 47, the costs directly related to the delivery of case management services.

Line 48 - Subtotal-Case Management Costs
Record total of lines 45 through 47. Line 48, column 7 is transferred to W/S 3, line A-5.

Lines 49 - 53 - Pharmacy Costs
Enter on lines 50 through 53, the costs directly related to the delivery of pharmacy services.

Line 54 - Subtotal-Pharmacy Costs
Record total of lines 50 through 53. Line 54, column 7 is transferred to W/S 3, line A-6.

Lines 56 - 60 - Dental Costs
Enter on lines 57 through 60, the costs directly related to the delivery of dental services.

Line 61 - Subtotal-Dental Costs
Record total of lines 57 through 60. Line 61, column 7 is transferred to W/S 3, line A-7.

Lines 66 - 88 - Cost of Non-Covered Services
Enter on lines 67 through 88, the costs directly related to the delivery of non-covered services.

Line 89 - Total Direct Costs of Non-covered Services
Record total of lines 67 through 88. Line 89, column 7 is transferred to W/S 3, line A-8.

Line 92 - Total Direct Costs
Line 92 is the total cost of all medical and health services provided by the PPCC (excluding overhead).

Lines 93 - 107 - Facility Costs
Enter on these lines the overhead cost related to the PPCC's facility. This includes the cost to own, lease or rent, and to maintain and improve PPCC buildings and building equipment

Line 108 - Subtotal-Facility Cost
Record total of lines 95 through 107.

Lines 110 - 130 - Administrative Costs
Enter on these lines the expenses related to the administration and management of the PPCC.

Line 131 - Subtotal-Administrative Costs
Record total of lines 111 through 130.

Line 133 - Total PPCC Overhead Costs
Line 133 is the total of facility and administrative costs incurred to operate the clinic. Line 133, column 7 is transferred to W/S 3, line A-9.

Line 136 - Total PPCC Cost

Line 136 is the total cost of the clinic.

WORKSHEET 1-A - RECLASSIFICATION OF EXPENSES

This worksheet provides for the reclassification of certain amounts reported on Worksheet 1, column 3 to reflect the proper cost allocation. The cost centers affected should be specifically identifiable in the facility's accounting records. Reclassifications are used in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet 1 are maintained in the facility's accounting books and records in one cost center. For example, if a physician performs administrative duties, the appropriate portion of his/her compensation, payroll taxes and fringe benefits should be reclassified from "Combined Health Care Staff Cost" to "Administrative Cost".

WORKSHEET 1-B - ADJUSTMENTS TO EXPENSES

This worksheet provides for the adjustments to the expenses listed on Worksheet 1, column 5. These adjustments, which are required under the PPCC Medicaid plan and/or Medicare principles of reimbursement, are to be made on the basis of "cost", or amount "received". Enter the total "amount received" (revenue) only if the cost (including the direct cost and all applicable overhead) cannot be determined: but if total direct and indirect cost can be determined, enter the "cost". Once an adjustment to an expense is made on the basis of "cost", the facility may not, in future cost reporting periods determine the required adjustment to the expense on the basis of "revenue". The following symbols are to be entered in column 4 to indicate the basis of adjustments: "A" for costs and "B" for amount received.

Types of items to be entered on this worksheet, but not limited to, are (1) those items which constitute recovery of expenses through sales, charges, fees, etc, and (2) those needed to adjust expenses incurred, (3) those items needed to adjust expenses in accordance with the PPCC Medicaid plan and/or Medicare principles of reimbursement.

Where an adjustment to an expense affects more than one cost center, the facility must record the adjustment to each cost center on a separate line on this worksheet.

WORKSHEET 2 - RECLASSIFICATION AND ADJUSTMENT OF TOTAL REPORTED CHARGES

General Instructions

This worksheet is used to record the charges for **all services provided by the clinic,** whether these services were charged to a Medicaid or non-Medicaid recipient. The charges are to be recorded from the PPCC's accounting books and records, in which the clinic is required to use a uniform charge structure for both Medicaid and non-Medicaid recipients. The reported charges should represent "usual and customary charges as billed by the provider of services" and as representing "a prevailing charge in the locality for comparable services under comparable circumstances."

This worksheet groups the charges together by type of service performed. Services charged to non-Medicaid patients **must** be grouped in the same manner as services charged to PPCC Medicaid patients. **Meaning:** all charges must be grouped by type of service as well as by type of recipient.

Not all of the listed charge centers will apply to each PPCC. For example, a PPCC might not provide optician services and would not, in that case, complete line 5.

Column 1 - TOTAL FACILITY CHARGES
The charges listed in this column must be in accordance with the PPCC's accounting books and records.

Enter on the appropriate lines in column 1 the total charges billed to all patients during the reporting period. The sum of columns 4 and 7 must equal column 1.

Column 2 - REPORTED CHARGES FOR NON-MEDICAID RECIPIENTS AND FOR NON-COVERED SERVICES

This column is used to record charges for services provided to non-Medicaid patients.

This column is used to record all charges **other than** PPCC Medicaid charges. Enter on the appropriate lines in column 2 the charges, for services, that were not paid for under the PPCC program, but were performed by the appropriate line's provider type. **For example,** a laboratory service was provided to a private pay patient by the clinic. Had the same service been provided to a Medicaid recipient, the service would have been billed to the PPCC program under the "70" provider type. However, since the service was provided to a non-Medicaid patient, the charge would be reported in line 2, column 2.

Column 3 - RECLASSIFICATIONS AND ADJUSTMENTS

Do not complete this column. This column is for desk review purposes only.

Column 4 - ADJUSTED CHARGES FOR NON-MEDICAID PATIENTS

Transfer the amounts from column 2 to the appropriate lines in column 4.

Column 5 - REPORTED CHARGES FOR MEDICAID PATIENTS

This column is used to record all Medicaid charges that **were paid** for under the PPCC program. Enter in column 5 the charges that relate to the line's appropriate provider type and code. **Do not** enter in this column any Medicaid charges that were billed to **another Medicaid program** other than the PPCC program, these charges should be entered in **column 2.** Also, do not enter in this column any PPCC Medicaid charges that were denied as non-covered services.

Column 6 - RECLASSIFICATIONS AND ADJUSTMENTS

Do not complete this column. This column is for desk review purposes only.

Column 7 - ADJUSTED CHARGES FOR MEDICAID PATIENTS

Transfer the amounts from column 5 to the appropriate lines in column 7.

LINE DESCRIPTION

On these lines enter the charges in the appropriate columns based on payment source, i.e., (column 5 for PPCC Medicaid recipients) and (column 2 for all others: private, Medicare, Managed Care, etc.). The sum of columns 2 and 5 must equal column 1.

Line 1 - INDEPENDENT CLINIC - 50
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "50" provider type, whether or not Medicaid was the payment source.

Line 2 - INDEPENDENT LABORATORY - 70
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "70" provider type, whether or not Medicaid was the payment source.

Line 3 - PODIATRIST - 30
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "30" provider type, whether or not Medicaid was the payment source.

Line 4 - OPTOMETRIST - 31

On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "31" provider type, whether or not Medicaid was the payment source.

Line 5 - OPTICIAN - 32
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "32" provider type, whether or not Medicaid was the payment source.

Line 6 - PSYCHIATRIC REHABILITATION - 87
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "87" provider type, whether or not Medicaid was the payment source.

Line 7 - HOME HEALTH AGENCY - 58
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "58" provider type, whether or not Medicaid was the payment source.

Line 8 - SUBTOTAL OF COMBINED CHARGES
Line 8 is the total charges for the clinic (excluding clinical social worker, psychologist, case management, pharmacy and dental charges). It is the sum of lines 1 through 8.

Line 9 - CLINICAL SOCIAL WORKER/PSYCHOLOGIST CHARGES
On this line enter the charges in the appropriate columns for services in which the performing provider is a certified clinical social worker or a clinical psychologist, whether or not Medicaid was the payment source.

Line 10 - SUBTOTAL OF CLINICAL SOCIAL WORKER/PSYCHOLOGIST
Line 10 is the total clinical social worker and clinical psychologist charges for the clinic. Transfer the amount in line 9 to line 10.

Line 11 - CASE MANAGEMENT CHARGES
On this line enter the charges in the appropriate columns for services in which the performing provider is a Medicaid authorized case management provider, whether or not Medicaid was the payment source.

Line 12 - SUBTOTAL OF CASE MANAGEMENT CHARGES
Line 12 is the total case management charges for the clinic. Transfer the amount in line 11 to line 12.

Line 13 - PHARMACY CHARGES
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "60" provider type, whether or not Medicaid was the payment source.

Line 14 - SUBTOTAL OF PHARMACY CHARGES
Line 14 is the total pharmacy charges for the clinic. Transfer the amount in line 13 to line 14.

Line 15 - DENTAL CHARGES
On this line enter the charges in the appropriate columns for services in which the performing provider bills Medicaid under the "40" provider type, whether or not Medicaid was the payment source.

Line 16 - SUBTOTAL OF DENTAL CHARGES
Line 16 is the total dental charges for the clinic. Transfer the amounts in line 15 to line 16.

Line 17 - TOTAL CHARGES
Line 17 is the total charges for the clinic. It is the sum of lines 8, 10, 12, 14 and 16.

WORKSHEET 3 - ALLOCATION OF OVERHEAD COSTS

Part A - DETERMINATION OF ALLOWABLE OVERHEAD COSTS

This part is used to determine allowable overhead costs for the PPCC. All overhead costs are allowed and defined as total allowable costs.

Part B - PERCENTAGE OF DIRECT COST CALCULATION

This part is used to determine the percentage of the health care cost centers to total direct health care costs.

Part C - CALCULATION OF ALLOWABLE OVERHEAD COSTS TO BE ALLOCATED

This part is used to determine the amount of allowable overhead costs to be allocated to each health care cost center.

Part D - ALLOCATION OF ALLOWABLE OVERHEAD COSTS TO DIRECT COSTS

This part is used to combine each health care cost center with the appropriate amount of allowable overhead costs.

WORKSHEET 4 - FINAL SETTLEMENT CALCULATION SHEET

Part A - CALCULATION OF CHARGE-TO-CHARGE RATIO

This part is used to determine the percentage of Medicaid charges to total charges for each health care charge center.

Part B - CALCULATION OF COST

This part is used to determine Medicaid costs for providing services to Medicaid recipients under the PPCC program. Medicaid costs are calculated by multiplying each health care cost center by the related charge-to-charge ratio for these services.

Part C - DETERMINATION OF TOTAL REIMBURSEMENT

This part is used to determine if an additional payment or recoupment is needed to adjust the interim payments (made by the state agency to the PPCC during the reporting period) to reflect 100% of reasonable costs.

INSTRUCTIONS FOR SCHEDULE A

SCHEDULE A - GRANTS AND GIFTS RECEIVED

General Instructions

This schedule is used to report all grants, gifts and income from endowments used during the cost reporting period. All such accounts must be reported on this schedule from the PPCC's accounting books and records.

Item 1 - Source of Federal Funds

Enter the grant award number and the date it was awarded. Also, enter the actual amount received by the center.

Item 2 - All Other Grants, Gifts and Income from Endowments

This section is used to record all donations and like items received during the cost reporting period.

Enter in the first column an identifiable description of the account. In the second column, indicate if the grant/gift was given a restricted use. If so, state the purpose of the restriction in the third column. In the fourth column, record the date in which the grant/gift was received. In the fifth column, record the amount of the grant/gift.

DOCUMENTATION MUST BE FURNISHED TO PROVIDE VERIFICATION OF ALL RESTRICTIONS, I.E., MEETING MINUTES, CONTRACT AGREEMENTS, ETC.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES

PRIMARY AND PRENATAL CARE CLINIC (PPCC)
FINANCIAL AND STATISTICAL REPORT
(Title XIX Cost Report)

1. PPCC Name and Address:

2. PPCC Provider Number:

3. Reporting Period:
From: To:

4. Type of Control (Check One Only)

GOVERNMENT	NONPROFIT ORGANIZATION	PROPRIETARY
__ STATE	__ CHURCH OPERATED	__ PROPRIETORSHIP
__ COUNTY		__ PARTNERSHIP
__ DISTRICT	__ CHURCH RELATED	__ CORPORATION
__ CITY		__ OTHER
__ OTHER	__ OTHER NONPROFIT	__ OTHER

5. PPCC Owned By:

6. Other Primary and prenatal Care clinics, Federally Qualified Health Centers, Rural Health Clinics, Hospitals, Nursing Facilities, Home Health Agencies, suppliers or Other Entities, that are owned or related through Common Ownership or Control to the Individual or Entity Listed in Item 5.

Provider Name	Location	Clinic or Provider Number

7. Names of Performing Provider's furnishing service at the Primary and Prenatal Care Clinic or under agreements and Medicaid Provider Number. (includes: physicians, dentists, nurse pract., etc.)

Name	Number	Name	Number

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I HEREBY CERTIFY that I have examined the accompanying cost report and supporting schedules prepared by _____ (provider name and number) for the reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is true, correct, and complete statement prepared from the books and records of the Primary and Prenatal Care Clinic in accordance with applicable instructions, except as noted.

Signature (Officer or Administrator of PPCC)	Title	Date
Name of Person Preparing this Report	Telephone Number	

Provider Name: _____
Period of Report: From: _____To:_____

Reclassification and Adjustment of
Trial Balance of Expenses

Worksheet 1
Page 1

	Cost Center	Compensation	Other	Total	Reclassifications	Reclassified Trial Balance	Adjustments	Net Expenses
		1	2	3	4	5	6	7
1	COMBINED HEALTH CARE STAFF COSTS:							
2	Physician							
3	Physician Assistant							
4	Nurse Practitioner							
5	Specialized Nurse Practitioner							
6	Nurse Midwife							
7	Visiting Nurse							
8	Other Nurse							
9	Laboratory Technician							
10	Radiology Technician							
11	Clinical Social Worker							
12	Clinical Psychologist							
13	Specialized Therapists (specify)							
14	Podiatrist							
15	Optometrist							
16	Other							
17	Other							
18	Other							
19	Other							
20	Other							
21	Other							
22	SUBTOTAL-COMBINED HEALTH CARE STAFF COSTS							
23								
24	OTHER COMBINED HEALTH CARE COSTS:							
25	Physician Services Under Agreement							
26	Physician Supervision Under Arrangements							
27	Medical Supplies							
28	Transportation (Health Care Staff)							
29	Depreciation-Medical Equipment							
30	Professional Liability Insurance							
31	Other							
32	Other							
33	Other							
34	SUBTOTAL-OTHER COMBINED HEALTH CARE COSTS							
35								
36	CLINICAL SOCIAL WORKER/PSYCHOLOGIST COSTS:							
37	Clinical Social Worker							
38	Clinical Psychologist							
39	Supplies-Clinical Social Worker							
40	Supplies-Clinical Psychologist							
41	Other (Specify)							
42	SUBTOTAL-CLINICAL SOCIAL WORKER/PSYCHOLOGIST COS							
43								
44	CASE MANAGEMENT COSTS:							
45	Salaries							
46	Supplies							
47	Other							
48	SUBTOTAL-CASE MANAGEMENT COSTS:							

Provider Name: _____
Period of Report: From: _____ To: _____

Reclassification and Adjustment of
Trial Balance of Expenses

Worksheet 1
Page 2

	Cost Center	Compensation	Other	Total	Reclassifications	Reclassified Trial Balance	Adjustments	Net Expenses
		1	2	3	4	5	6	7
49	PHARMACY COSTS:							
50	Pharmacist							
51	Drugs Sold							
52	Supplies							
53	Other							
54	SUBTOTAL - PHARMACY COSTS							
55								
56	DENTAL COSTS:							
57	Denist							
58	Dental Assistant							
59	Dental Supplies							
60	Other							
61	SUBTOTAL - DENTAL COSTS							
62								
63	TOTAL DIRECT COSTS OF COVERED SERVICES (L-22, 34, 42,							
64								
65								
66	COST OF NON-COVERED SERVICES:							
67	(Specify)							
68	(Specify)							
69	(Specify)							
70								
71								
72								
73								
74								
75								
76								
77								
78								
79								
80								
81								
82								
83								
84								
85								
86								
87								
88								
89	TOTAL DIRECT COSTS OF NON-COVERED SERVICES							
90								
91								
92	TOTAL DIRECT COSTS (Sum of lines 63 and 89)							

Provider Name: _____
Period of Report: From: _____ To: _____

Reclassification and Adjustment of
Trial Balance of Expenses

Worksheet 1
Page 3

	Cost Center	Compensation	Other	Total	Reclassifications	Reclassified Trial Balance	Adjustments	Net Expenses
		1	2	3	4	5	6	7
93	OVERHEAD COSTS:							
94	FACILITY COST:							
95	Rent							
96	Insurance-Property							
97	Interest on Mortgage/Loans							
98	Utilities							
99	Depreciation-Buildings							
100	Depreciation-Equipment							
101	Housekeeping/Maintenance							
102	Property Taxes							
103	Other (Specify)							
104	Other							
105	Other							
106	Other							
107	Other							
108	SUBTOTAL-FACILITY COST							
109								
110	ADMINISTRATIVE COST:							
111	Office Salaries							
112	Depreciation-Office Equipment							
113	Office Supplies							
114	Medical Records							
115	Legal & Accounting							
116	Insurance (Specify)							
117	Telephone							
118	Vehicle Expense							
119	Travel & Seminars							
120	Other (Specify)							
121	Other							
122	Other							
123	Other							
124	Other							
125	Other							
126	Other							
127	Other							
128	Other							
129	Other							
130	Other							
131	SUBTOTAL-ADMINISTRATIVE COST							
132								
133	TOTAL PPCC OVERHEAD COSTS (Sum of lines 108 & 131)							
134								
135								
136	TOTAL PPCC COST (Sum of lines 92 & 133)							

Provider Name: _____ Reclassification and Adjustment of Worksheet 2

Period of Report: From: _____ To: _____ Provider's Charges

	Provider Type--Code	Total Facility Charges	Reported Charges For Non-Medicaid Recipients	Reclassifications & Adjustments (for audit use only)	Adjusted Charges For Non-Medicaid Recipients	Reported Charges For Medicaid Recipients	Reclassifications & Adjustments (for audit use only)	Adjusted Charges For Medicaid Recipients
		1	2	3	4	5	6	7
1	INDEPENDENT CLINIC--50							
2	INDEPENDENT LABORATORY--70							
3	PODIATRIST--30							
4	OPTOMETRIST--31							
5	OPTICIAN--32							
6	PSYCHIATRIC REHABILITATION--87							
7	HOME HEALTH AGENCY--58							
8	COMBINED - SUBTOTAL (Sum of Lines 1 thru 7							
9	CLINICAL SOCIAL WORKER/PSYCHOLOGIST							
10	CLINICAL SOCIAL/PSYCH - SUBTOTAL							
11	CASE MANAGEMENT							
12	CASE MANAGEMENT - SUBTOTAL							
13	PHARMACY--60							
14	PHARMACY - SUBTOTAL							
15	DENTIST--40							
16	DENTAL - SUBTOTAL							
17	TOTAL (Sum of Lines 8, 10, 12, 14 and 16)							

Provider Name: _____
Period of Report: From: _____ To: _____

Reclassification Of Expenses **Worksheet 1-A**

	EXPLANATION OF ENTRY	INCREASE				DECREASE				
		CODE	COST CENTER	Line No.	AMOUNT	COST CENTER	Line No.	AMOUNT	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36									36
37									37
38									38

Provider Name: _____

Period of Report: From: _____To:_____

WORKSHEET 1-B
ADJUSTMENTS TO EXPENSES

Expense Classification on Worksheet 1 to be Adjusted (1)	Line No. (2)	Amount (3)	Basis for Adjust-ment (4)	Description of Adjustment (5)

Provider Name: _____ **Worksheet 3**
Period of Report: From: _____ To: _____

ALLOCATION OF OVERHEAD COSTS

Part A - Determination of Allowable Overhead Costs	
1. Total Combined Health Care Staff Costs (W/S 1, Page 1, Col. 7, Line 22)	
2. Total Combined Other Health Care Costs (W/S 1, Page 1, Col. 7, Line 34)	
3. Total Combined Health Care Costs (Sum of lines A1 and A2)	
4. Total Clinical Social Worker/Psychologist Costs (W/S 1, Page 1, Col. 7, Line 42)	
5. Total Case Management Costs (W/S 1, Page 1, Col. 7, Line 48)	
6. Total Pharmacy Costs (W/S 1, Page 2, Col. 7, Line 54)	
7. Total Dental Costs (W/S 1, Page 2, Col. 7, Line 61)	
8. Total Cost of Non-Covered Services (W/S 1, Page 2, Col. 7, Line 89)	
9. Total Overhead Costs (W/S 1, Page 3, Col. 7, Line 133)	
10. Total Costs (Sum of Lines A3, A4, A5, A6, A7, A8 and A9)	
11. Allowable Overhead Cost (A9)	
Part B - Percentage of Direct Cost Calculation	
1. Total Direct Costs (W/S 1, Page 2, Col. 7, Line 92)	
2. Combined Health Care Costs Percentage (W/S 3, Line A3 Divided By W/S 3, Line B1)	
3. Clinical Social/Psych Costs Percentage (W/S 3, Line A4 Divided By W/S 3, Line B1)	
4. Case Management Costs Percentage (W/S 3, Line A5 Divided By W/S 3, Line B1)	
5. Pharmacy Costs Percentage (W/S 3, Line A6 Divided By W/S 3, Line B1)	
6. Dental Costs Percentage (W/S 3, Line A7 Divided By W/S 3, Line B1)	
7. Cost of Non-Covered Services Percentage (W/S 3, Line A8 Divided By W/S 3, Line B1)	
Part C - Calculation of Allowable Overhead Costs To Be Allocated	
1. Allowable Overhead Costs To Be Allocated To Combined Health Care Costs (W/S 3, Line A11 Multiplied By W/S 3, Line B2)	
2. Allowable Overhead Costs To Be Allocated To Clinical Social/Psych Costs (W/S 3, Line A11 Multiplied By W/S 3, Line B3)	
3. Allowable Overhead Costs To Be Allocated To Case Management Costs (W/S 3, Line A11 Multiplied By W/S 3, Line B4)	
4. Allowable Overhead Costs To Be Allocated To Pharmacy Costs (W/S 3, Line A11 Multiplied By W/S 3, Line B5)	
5. Allowable Overhead Costs To Be Allocated To Dental Costs (W/S 3, Line A11 Multiplied By W/S 3, Line B6)	
6. Allowable Overhead Costs To Be Allocated To Cost of Non-Covered Services (W/S 3, Line A11 Multiplied By W/S 3, Line B7)	
Part D - Allocation of Allowable Overhead Costs To Direct Costs	
1. Total Combined Health Care Costs including Allowable Overhead (Sum of W/S 3, Line A3 and W/S 3, Line C1)	
2. Total Clinical Social Worker/Psychologist Costs including Allowable Overhead (Sum of W/S 3, Line A4 and W/S 3, Line C2)	
3. Total Case Management Costs including Allowable Overhead (Sum of W/S 3, Line A5 and W/S 3, Line C3)	
4. Total Pharmacy Costs including Allowable Overhead (Sum of W/S 3, Line A6 and W/S 3, Line C4)	
5. Total Dental Costs including Allowable Overhead (Sum of W/S 3, Line A7 and W/S 3, Line C5)	
6. Total Cost of Non-Covered Services including Allowable Overhead (Sum of W/S 3, Line A8 and W/S 3, Line C6)	

Provider Name: _____ Worksheet 4
Period of Report: From: _____To:_____

FINAL SETTLEMENT CALCULATION SHEET

Part A - Calculation of Charge-to-Charge Ratio	
1. Medicaid Combined Health Care Charges (W/S 2, Col. 7, Line 8)	
2. Total Combined Charges (W/S 2, Col. 1, Line 8)	
3. Combined Health Care Services Ratio (W/S 4, Line A1 Divided By W/S 4, Line A2)	
4. Medicaid Clinical Social/Psych Charges (W/S 2, Col. 7, Line 10)	
5. Total Clinical Social/Psych Charges (W/S 2, Col. 1, Line 10)	
6. Clinical Social/Psych Services Ratio (W/S 4, Line A4 Divided By W/S 4, Line A5)	
7. Medicaid Case Management Charges (W/S 2, Col. 7, Line 12)	
8. Total Case Management Charges (W/S 2, Col. 1, Line 12)	
9. Case Management Services Ratio (W/S 4, Line A7 Divided By W/S 4, Line A8)	
10. Medicaid Pharmacy Charges (W/S 2, Col. 7, Line 14)	
11. Total Pharmacy Charges (W/S 2, Col. 1, Line 14)	
12. Pharmacy Services Ratio (W/S 4, Line A10 Divided By W/S 4, Line A11)	
13. Medicaid Dental Charges (W/S 2, Col. 7, Line 16)	
14. Total Dental Charges (W/S 2, Col. 1, Line 16)	
15. Dental Services Ratio (W/S 4, Line A13 Divided By W/S 4, Line A14)	

Part B - Calculation of Cost	
1. Total Combined Health Care Costs (W/S 3, Line D1)	
2. Medicaid Combined Health Care Costs (W/S 4, Line A3 Multiplied By W/S 4, Line B1)	
3. Total Clinical Social/Psych Costs (W/S 3, Line D2)	
4. Medicaid Clinical Social/Psych Costs (W/S 4, Line A6 Multiplied By W/S 4, Line B3)	
5. Total Case Management Costs (W/S 3, Line D3)	
6. Medicaid Case Management Costs (W/S 4, Line A9 Multiplied By W/S 4, Line B5)	
7. Total Pharmacy Costs (W/S 3, Line D4)	
8. Medicaid Pharmacy Costs (W/S 4, Line A12 Multiplied By W/S 4, Line B7)	
9. Total Dental Costs (W/S 3, Line D5)	
10. Medicaid Dental Costs (W/S 4, Line A15 Multiplied By W/S 4, Line B9)	

Part C - Determination of Total Reimbursement	
1. Total Medicaid Costs (Sum of W/S 4, Lines B2, B4, B6, B8 and B10)	
2. Deductions From Payments (such as copayments, third party liabilities, etc.)	
3. Payments By Medicaid To PPCC During The Reporting Period	
4. Balance Due To / (Due From) Provider (W/S 4, Line C1, Less W/S 4, Lines C2 and C3)	

Provider Name: ______________________________
Period of Report: From: __________To:__________

SCHEDULE A
Grants and Gifts Received

1. Source of Federal Funds	Grant Award No.	Date	Amount
A. Community Health Center (Section 330 (d), Public Health Service Act)			
B. Migrant Health Center (Section 329 (d), PHS Act)			
C. Health Services for the Homeless (Section 340 (d), PHS Act)			
D. Other (Specify)			
E. Other (Specify)			
F. Other (Specify)			

LIST ALL OTHER GRANTS, GIFTS AND INCOME FROM ENDOWMENTS

2. Source or Type of Funds	Mark, If Restricted	If Restricted, Please State Purpose	Date	Amount