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|--|---|-----------------------------------|---------------|
| CALCULATION OF REIMBURSEMENT SETTLEMENT COMMUNITY MENTAL HEALTH CENTER PROVIDER SERVICES | PROVIDER CCN:<br>_____<br>COMPONENT CCN:<br>_____ | PERIOD:<br>FROM _____<br>TO _____ | WORKSHEET J-3 |
|--|---|-----------------------------------|---------------|

|                       |   |
|-----------------------|---|
| Check applicable box: | <input type="checkbox"/> Title V<br><input type="checkbox"/> Title VIII<br><input type="checkbox"/> Title XIX |
|-----------------------|---|

|   |   | PROGRAM COST |       |
|---|---|--------------|-------|
| 1                                       | Cost of component services (from Wkst. J-2, Pt. II, line 29)  |              | 1     |
| 2                                       | PPS payments received excluding outliers  |              | 2     |
| 3                                       | Outlier payments  |              | 3     |
| 4                                       | Primary payer payments  |              | 4     |
| 5                                       | Total reasonable cost (see instructions)  |              | 5     |
| 6                                       | Total charges for program services  |              | 6     |
| CUSTOMARY CHARGES                       |   |              |       |
| 7                                       | Aggregate amount actually collected from patients liable for services on a charge basis   |              | 7     |
| 8                                       | Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) |              | 8     |
| 9                                       | Ratio of line 7 to line 8 (not to exceed 1.000000) (see instructions)   |              | 9     |
| 10                                      | Total customary charges (see instructions)  |              | 10    |
| 11                                      | Excess of customary charges over reasonable cost (see instructions)   |              | 11    |
| 12                                      | Excess of reasonable cost over customary charges (see instructions)   |              | 12    |
| COMPUTATION OF REIMBURSEMENT SETTLEMENT |   |              |       |
| 13                                      | Total reasonable cost (from line 5)   |              | 13    |
| 14                                      | Part B deductible billed to program patients  |              | 14    |
| 15                                      | Net cost (line 13 minus line 14)  |              | 15    |
| 16                                      | Excess of reasonable cost over customary charges (from line 12)   |              | 16    |
| 17                                      | Subtotal (line 15 minus line 16)  |              | 17    |
| 18                                      | 80 percent of costs (80% of line 17) (see instructions)   |              | 18    |
| 19                                      | Actual coinsurance billed to program patients (from provider records)   |              | 19    |
| 20                                      | Net cost less actual billed coinsurance (line 17 minus line 19)   |              | 20    |
| 21                                      | Allowable bad debts (from provider records) (see instructions)  |              | 21    |
| 22                                      | Adjusted reimbursable bad debts (see instructions)  |              | 22    |
| 23                                      | Allowable bad debts for dual eligible beneficiaries (see instructions)  |              | 23    |
| 24                                      | Net reimbursable amount (see instructions)  |              | 24    |
| 25                                      | Other adjustments (see instructions) (specify)  |              | 25    |
| 25.50                                   | Pioneer ACO demonstration payment adjustment (see instructions)   |              | 25.50 |
| 25.99                                   | Demonstration payment adjustment amount before sequestration  |              | 25.99 |
| 26                                      | Total cost (see instructions)   |              | 26    |
| 26.01                                   | Sequestration adjustment (see instructions)   |              | 26.01 |
| 26.02                                   | Demonstration payment adjustment amount after sequestration   |              | 26.02 |
| 27                                      | Interim payments (see instructions)   |              | 27    |
| 28                                      | Tentative settlement (for contractor use only)  |              | 28    |
| 29                                      | Balance due component/program (line 26 minus lines 26.01, 26.02, 27, and 28)  |              | 29    |
| 30                                      | Protested amounts (nonallowable cost report items in accordance with CMS Pub. 15-2, chapter 1, §115.2)  |              | 30    |