

**Instructions for Preparing and Submitting the FY 2014
Health Center Program (H80) Budget Period Progress Report
Non-Competing Continuation (NCC)**

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Table 1: Submission Schedule

NCC Cycle Number	Budget Period Start Date	EHB Access to Submission	EHB Deadline (5:00 PM ET)
5-H80-14-001	November 1, 2013	July 10, 2013	August 14, 2013
5-H80-14-002	December 1, 2013	July 24, 2013	September 11, 2013
5-H80-14-003	January 1, 2014	August 21, 2013	October 2, 2013
5-H80-14-004	February 1, 2014	September 18, 2013	October 30, 2013
5-H80-14-005	March 1, 2014	October 23, 2013	December 4, 2013
5-H80-14-006	April 1, 2014	November 13, 2013	January 8, 2014
5-H80-14-007	May 1, 2014	December 11, 2013	February 5, 2014
5-H80-14-008	June 1, 2014	January 22, 2014	March 5, 2014

Revision August 9: Clarified that the salary limitation applies to all HRSA funding (page 14)

Instructions for Preparing and Submitting the FY 2014 Health Center Program (H80) Budget Period Progress Report Non-Competing Continuation (NCC)

This Budget Period Progress Report (BPR) non-competiting continuation will provide funding for the FY 2014 budget year (budget periods starting November 1, 2013 – September 1, 2014).

I. TECHNICAL ASSISTANCE

A technical assistance website has been established to assist grantees in completing the BPR. The site includes copies of forms, frequently asked questions (FAQs), and a slide presentation, among other resources. It can be accessed at <http://bphc.hrsa.gov/policiesregulations/continuation>.

Grantees may obtain additional information regarding business, administrative, or fiscal issues by contacting:

Carolyn Testerman
Office of Federal Assistance Management
HRSA Division of Grants Management Operations
301-594-4244
ctesterman@hrsa.gov

Grantees may obtain programmatic technical assistance by contacting:

René Herbert and Vesnier Lugo
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
BPHCBPR@hrsa.gov

Grantees may obtain assistance with system problems encountered when completing the application in EHB by contacting the BPHC Helpline at 1-877-974-2742 or BPHCHelpline@hrsa.gov.

II. GENERAL INSTRUCTIONS

The BPR must not exceed 40 pages when printed by HRSA (approximately 5 MB). Submit single-spaced narrative documents with 12-point, easily readable font (e.g., Times New Roman, Arial, Courier) and 1-inch margins. Smaller font (no less than 10-point) may be used for tables, charts, and footnotes. Grantees are reminded that failure to include all required documents and information will result in the progress report being considered incomplete or non-responsive. Incomplete or non-responsive progress reports will be returned to the grantee through a “request change” notification via EHB to provide missing

documentation or clarify a portion of the submitted report. **Failure to submit the BPR by the established deadline or submission of an incomplete or non-responsive progress report may result in a delay in Notice of Award issuance or a lapse in funding.** Therefore, it is recommended that grantees carefully review their BPR to ensure it is both complete and responsive prior to submission.

Significant budget revisions or other significant changes to the grant (e.g., change in Project Director/CEO, change in scope of project) must be requested via the Prior Approval Module or Change in Scope Module in EHB, as appropriate. Significant budget revisions occur when cumulative transfers among budget categories exceed 25 percent of the total approved budget (inclusive of direct and indirect costs) or \$250,000, whichever is less. For further detail on actions and changes requiring prior approval, review the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants/hhsgrantspolicy.pdf>.

The following tables identify the components for the BPR submission. In the Form Type column of [Tables 2-3](#), the word “E-Form” refers to forms that are completed online through EHB and **DO NOT** require downloading or uploading. The word “Document” refers to materials that must be downloaded, completed in the template provided, and uploaded into EHB. The word “Fixed” refers to forms that cannot be altered. Appendix A provides detailed instructions on the required forms and documents.

Note: No table of contents is required.

Table 2: Submission Components

Progress Report Section	Form Type	Instructions	Counted in Page Limit?
SF-PPR and SF-PPR-2 (Required)	E-Form	Complete the form online. Specific instructions are included in the BPR EHB user guide available within EHB and at http://bphc.hrsa.gov/policiesregulations/continuation .	No
Budget Information: Budget Details (Required)	E-Form	Complete the form online. Refer to Section IV for detailed instructions.	No
Budget Narrative (Required)	Document	Upload the Budget Narrative. Refer to Section IV for detailed instructions.	Yes
Program Specific Forms (Required)	Varies	See Table 3 and refer to Appendix A for detailed instructions.	No

Table 3: Program Specific Forms

- Refer to **Appendix A** for detailed instructions on completing the forms/documents listed below, unless otherwise noted.
- The Program Specific Forms DO NOT count against the page limit.

Program Specific Forms	Form Type	Instructions
Federal Object Class Categories (Required)	E-Form	Complete this form to provide details on the federal and non-federal budget request. A sample is available at http://bphc.hrsa.gov/policiesregulations/continuation .
Form 2 : Staffing Profile (Required)	E-Form	Complete the form online to describe staffing for the upcoming budget period. A sample is available at http://bphc.hrsa.gov/policiesregulations/continuation .
Form 3 : Income Analysis (Required)	Document	Complete the document using the template provided in EHB and upload as an attachment within the Income Analysis Section of the Program Specific forms. A sample is available at http://bphc.hrsa.gov/policiesregulations/continuation .
Form 5A : Services Provided (Informational/Read Only)	Fixed	This form is pre-populated to reflect the current scope of project. Changes must be requested via Change in Scope (CIS) or self-update. Contact your project officer for guidance.
Form 5B : Service Sites (Informational/Read Only)	Fixed	This form is pre-populated to reflect the current scope of project. Changes must be requested via CIS or self-update. Contact your project officer for guidance.
Form 5C : Other Activities/Locations (Informational/Read Only)	Fixed	This form is pre-populated to reflect the current scope of project. Changes must be requested via CIS or self-update. Contact your project officer for guidance.
Program Narrative Update (Required)	E-Form	Respond to the questions found in the Instructions for Program Narrative Update .

III. INSTRUCTIONS FOR PROGRAM NARRATIVE UPDATE

The Program Narrative Update must address progress and changes that have impacted the community/target population and grantee organization over the past year. It must also address plans for the upcoming FY 2014 budget period. Respond to each item below and ensure consistency between the Program Narrative Update and other components of the BPR submission.

NEW for FY 2014: The Program Narrative Update will be provided directly in EHB (it will no longer be an attached narrative document). The character/page limitations for each Program Narrative Update section are listed below.

Describe the following for the FY 2013 budget period and any predicted changes for the FY 2014 budget period.

1. **Environment (3,000 characters = approximately 1 page):** Discuss broad changes in the region, state, and/or community over the past year that have impacted the project (e.g., changing service area demographics/shifting target population needs, changes in major health care providers in the service area, changes in key program partnerships, Affordable Care Act implementation at the state/local level).
2. **Organizational Capacity (3,000 characters = approximately 1 page):** Discuss major changes in the organization's capacity over the past year that have impacted or may impact the implementation of the funded project, including changes in:
 - Staffing, including staff composition and/or key staff vacancies
 - Sites
 - Systems, including financial, clinical, and/or practice management systems
 - Financial status
3. **Patient Capacity (3,000 characters = approximately 1 page):** Discuss the trend in unduplicated patients and report progress in reaching the projected number of patients to be served by the end of the project period in the identified categories. Explain significant changes in patient numbers and discuss progress toward reaching the projected patient goals, including the key factors impacting patient numbers. Maintenance or increases in patient numbers are expected; decreasing trends or limited progress towards the projected patient goals must be explained.

Table 4: Patient Capacity

	2010 Patient Number	2011 Patient Number	2012 Patient Number	Projected Number of Patients**	Patient Capacity Narrative
Total Unduplicated Patients (inclusive of the categories below)	Pre-populated from 2010 UDS	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2010 UDS	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2010 UDS	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Total Public Housing Resident Patients	No pre-populated data*	No pre-populated data*	No pre-populated data*	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit

*Special Populations patient numbers are pre-populated from Table 4 in the UDS Report. Since public housing patients are not included in this table, no information is pre-populated for these patients. Provide public housing patient numbers from your health center data, if applicable.

**The information in the Projected Number of Patients column is pre-populated from the application/submission that initiated your current budget period (SAC/BPR). If you were awarded a FY 2013 New Access Point (NAP) Satellite Grant, the patient projection in your NAP application has been added to the projection from the application/submission that initiated your current budget period (SAC/BPR).

If pre-populated patient projections are not accurate, adjusted projections should be provided and explained (e.g., overall patient projection has increased due to a capital development grant award) in the Patient Capacity Narrative section.

4. Supplemental Awards (3,000 character limits = approximately 1 page):

Discuss progress made in implementing recent supplemental Health Center Program awards, as applicable. For each of the following, as applicable, describe:

- a. Progress toward goals (programmatic and/or numeric);

- b. Key factors impacting progress (both contributing and restricting) toward goals; and
- c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

Table 5: Supplemental Awards

	Programmatic Goal	Numeric Goal (if applicable)	Supplemental Award Narrative (if applicable)
FY 2012 Quality Improvement Supplement	Achieve/increase the level of Patient Centered Medical Home (PCMH) recognition and increase cervical cancer screening rates	Not Applicable	3,000 character limit
FY 2012 HIV Supplement	Increase the number of patients living with HIV/AIDS (PLWHA) receiving medical care	Pre-populated with the number of new PLWHA to receive medical care	3,000 character limit
FY 2013 Outreach and Enrollment (O/E) Assistance Supplement	Increase number of O/E staff trained; increase number of individuals assisted; and increase number of individuals enrolled	Pre-populated with numbers to be trained, assisted, and enrolled	3,000 character limit
FY 2012 New Access Point (NAP) Satellite Grant	Achieve operational status and increase number of patients	Pre-populated with end of project period patient projection	3,000 character limit
FY 2013 New Access Point (NAP) Satellite Grant	Achieve operational status, and increase number of patients	Pre-populated with end of project period patient projection	3,000 character limit

- 5. Clinical/Financial Performance Measures (3,000 characters = approximately 1 page):** Discuss the trends in clinical/financial performance measures and report progress in reaching the projected goals by the end of the project period in the identified categories. Explain significant changes in any of the performance measures listed under each of the five performance measure categories and discuss progress toward reaching the projected goals, including key factors impacting performance. Maintenance or improvement in performance is expected; decreasing trends or limited progress towards the projected goals must be explained.

Table 6: Performance Measures

	2010 Measures	2011 Measures	2012 Measures	Measure Goals*	Measure Narrative
Perinatal Health					
Access to prenatal care in 1st trimester**	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Low birth weight (< 2500 grams)**	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Preventive Health Screenings and Services					
Weight assessment and counseling for children and adolescents (ages 2-17)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Adult weight screening and follow up	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Adult tobacco use assessment	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Adult tobacco cessation counseling for tobacco users	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	

	2010 Measures	2011 Measures	2012 Measures	Measure Goals*	Measure Narrative
Colorectal cancer screening (ages 51-75)**	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Cervical cancer screening (ages 21-64)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Childhood immunizations (by 2nd birthday)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Chronic Disease Management					
Asthma treatment – pharmacologic therapy (ages 5-40)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit
Coronary artery disease (CAD) and lipid-lowering therapy (adult)**	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Ischemic Vascular Disease (IVD) and aspirin or other anti-thrombotic therapy (adult)**	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Blood pressure control (adult hypertensive patients with blood pressure < 140/90)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Diabetes control (diabetic patients ages 18-75 with HbA1c <= 9%)	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Financial Measures					
Total cost per patient	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	3,000 character limit

	2010 Measures	2011 Measures	2012 Measures	Measure Goals*	Measure Narrative
Medical cost per medical visit	Pre-populated from 2010 UDS (if available)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from the SAC/BPR that initiated the current budget period	
Change in Net Assets to Expense Ratio***	Pre-populated from 2010 audit data (if available)	Pre-populated from 2011 audit data (if available)	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period	
Long Term Debt to Equity Ratio***	Pre-populated from 2010 audit data (if available)	Pre-populated from 2011 audit data (if available)	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period	
Working Capital to Monthly Expense Ratio***	Pre-populated from 2010 audit data (if available)	Pre-populated from 2011 audit data (if available)	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period	
Other Measures					
Behavioral Health	Provide data if available	Provide data if available	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period and any supplements awarded during the budget period	3,000 character limit
Oral Health	Provide data if available	Provide data if available	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period and any supplements awarded during the budget period	
Other Measures (if applicable)	Provide data if available	Provide data if available	Provide data if available	Pre-populated from the SAC/BPR that initiated the current budget period and any supplements awarded during the budget period	
<p>* Measure Goals are pre-populated from the Projected Data (by End of Project Period) in the application/ submission that initiated your current budget period (SAC/BPR). If pre-populated performance measure goals are not accurate, adjusted goals should be provided and explained (e.g., goal for the diabetes measure has increased based on improved patient tracking via a new EHR) in the appropriate Measure</p>					

	2010 Measures	2011 Measures	2012 Measures	Measure Goals*	Measure Narrative
Narrative section.					
**If no Projected Data was provided in the application/submission that initiated your current budget period (SAC/BPR), provide a percentage goal for the end of the project period.					
***Does not apply to Tribal and public entities.					

The following resources may be useful in analyzing performance measure progress:

- UDS Reporting Manual: <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2012udsmanual.pdf>
- UDS TA Site: <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/index.html>

IV. BUDGET PRESENTATION INSTRUCTIONS

A complete budget presentation includes the submission of the Budget Information: Budget Details form, Federal Object Class Categories form, budget narrative, and [Form 3](#) – Income Analysis.

NEW for FY 2014: The Federal Object Class Categories form has been added to capture details on the federal funding requested.

Note: In the formulation of your budget presentation, per section 330(e)(5)(A) of the PHS Act (42 U.S.C. 254b), the amount of grant funds awarded to an organization in any fiscal year may not exceed the costs of health center operations in such fiscal year less the total of: state, local, and other operational funding provided to the center; and the fees, premiums, and third-party reimbursements, which the center may be expected to receive for its operations in such fiscal year.

The BPR may not be used to request changes in the total, type (i.e., Community Health Center – CHC, Migrant Health Center – MHC, Health Care for the Homeless – HCH, and/or Public Housing Primary Care – PHPC), or allocation of Health Center Program funds between funding types.

A. Budget Information: Budget Details Form (Required)

In Section A: Budget Summary, verify the pre-populated list of Health Center Program funding types (i.e., CHC, MHC, HCH, and/or PHPC). If the funding types are incorrect, make necessary adjustments using the **Update Sub-Program** button.

In the Federal column, provide the Health Center Program grant request for each Health Center Program funding type (e.g., CHC, MHC). The total federal funding requested across all Health Center Program funding types must equal the Recommended Federal Budget figure that is pre-populated at the top of the Budget Information: Budget Details

form. This figure corresponds with the recommended future support figure (Item 13 or 19) on the most recent Notice of Award.

In the Non-Federal column, provide the total of the non-federal funding sources for each type of Health Center Program (e.g., CHC, MHC). The total for the Non-Federal column should equal the Total Non-Federal value on [Form 3](#): Income Analysis. The amount(s) in the total column will be calculated automatically as the sum of the federal and non-federal columns.

In Section B: Budget Categories, each column should reflect the total budget (federal and non-federal funding) by object class category for each section 330 program for which funding is requested (e.g., CHC, MHC). Each line represents a distinct object class category that must be addressed in the budget justification.

The amounts in the Total Direct Charges row and the Total column will be calculated automatically. Indirect costs may only be claimed with an approved indirect cost rate (see details in the Budget Narrative section below).

In Section C: Non-Federal Resources, provide a breakdown of non-federal funds by funding source (e.g., state, local) for each type of Health Center Program funding (e.g., CHC, MHC). If the grantee is a State agency, the State column should be left blank and State funding should be included in the Applicant column. Note that Program Income must be consistent with the Total Program Income presented in [Form 3](#): Income Analysis.

Salary Limitation

The Consolidated Appropriations Act, 2012 (P.L. 112-74) limits the salary amount that may be awarded and charged to HRSA grants. Award funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II of the Federal Executive Pay scale (currently \$179,700). This amount reflects an individual's base salary **exclusive of fringe benefits** and income that an individual may be permitted to earn outside of the duties to your organization (i.e., the rate limitation only limits the amount that may be awarded and charged to HRSA grants). This salary limitation also applies to sub-awards/subcontracts under a HRSA grant.

Example of Application of this Limitation

If an individual's base salary is \$225,000 per year plus fringe benefits of 25 percent (\$56,250), and that individual is devoting 50 percent of his/her time to this award, the base salary must be adjusted to \$179,700 plus fringe benefits of 25 percent (\$44,925). This results in a total of \$112,312 that may be included in the project budget and charged to the award in salary/fringe benefits for this individual. See the breakdown in the table below.

Table 7: Salary Limitation – Actual vs. Claimed

Current Actual Salary	
Individual's actual base full time salary: \$225,000 (50% of time will be devoted to the project).	
Direct Salary	\$112,500
Fringe (25% of salary)	\$ 28,125
Total	\$140,625
Amount of Actual Salary Eligible to be Claimed on the Application Budget due to the Legislative Salary Limitation	
Individual's base full time salary adjusted to Executive Level II: \$179,700 (50% of time will be devoted to the project).	
Direct Salary	\$ 89,850
Fringe (25% of salary)	\$ 22,462
Total	\$112,312

B. Budget Narrative (Required)

NEW for FY 2014: The budget justification must detail the costs of each line item within each object class category from the [Federal Object Class Categories](#) form (federal section 330 request and non-federal (non-section 330) funding). The budget justification must contain sufficient detail to enable HRSA to determine if costs are allowable.

Include a line-item budget narrative which explains the amounts requested for each row on the Federal Object Class Categories form. The budget narrative (often referred to as the budget justification) is for **ONE year based on your upcoming 12-month budget period (this period will follow immediately after the current budget period listed on your Notice of Award)**.

The one-year budget narrative must itemize **revenues AND expenses** of your federal request and non-federal contribution and clearly explain each line-item within each cost element. It is important to **ensure that the budget justification contains detailed calculations explaining how each line-item expense is derived** (e.g., number of visits, cost per unit). Refer to the HHS Grants Policy Statement available at <http://www.hrsa.gov/grants> for information on allowable costs.

Upload the budget narrative in the Budget Narrative Form section in EHB. Include the following in the budget justification:

Personnel Costs: Personnel costs must be explained by listing the exact amount requested each year. **Reminder:** Award (federal section 330) funds may not be used to pay the salary of an individual at a rate in excess of Federal Executive Level II or \$179,700.¹ An individual's base salary, per se, is **not** constrained by the legislative provision; the rate limitation restricts the amount of the salary that may be charged to

¹ While the BPR focuses on application of the salary limitation to the federal section 330 grant funds, the salary limitation applies across all HRSA funding. In other words, if a full-time staff member is paid from several HRSA grants, the total federal contribution to that staff person's salary cannot exceed \$179,700.

the Health Center Program grant. Provide all base salaries at the full amount even if they exceed the salary limit.

See Table 8 below for the information that must be included for each staff position supported in whole or in part with federal section 330 grant funds. Staff supported entirely with non-federal funds do not require this level of information; grantees should reference [Form 2](#): Staffing Profile in the justification for such staff.

Table 8: Budget Justification Sample for Salary Limitation

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50	\$225,000	\$179,700	\$89,850
R. Doe	Nurse Practitioner	100	\$ 75,950	no adjustment needed	\$75,950
D. Jones	Data/AP Specialist	25	\$ 33,000	no adjustment needed	\$ 8,250

Fringe Benefits: List the components of the fringe benefit rate (e.g., health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement). Fringe benefits must be directly proportional to the portion of personnel costs.

Travel: List travel costs categorized by local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel, and staff members/patients/board members completing the travel must be outlined. The budget must also reflect travel expenses associated with participating in proposed meetings, trainings, or workshops.

Equipment: Identify the cost per item and justify the need for each piece of equipment to carry out the proposed project. Equipment includes moveable items that are non-expendable, tangible personal property having a useful life of more than 1 year and an acquisition cost that equals or exceeds the lesser of (a) the capitalization level established by the grantee for its financial statement purposes, or (b) \$5,000. Furniture, administrative equipment (i.e., computers, servers, telephones, fax machines, copying machines, software) and special purpose equipment used for medical activities (e.g., stethoscopes, blood pressure monitors, scales, electronic thermometers) with a useful life of one year or greater and a unit cost of less than \$5,000 may also be included.

Supplies: List the items necessary for implementing the proposed project, separating items into three categories: office supplies (e.g., paper, pencils), medical supplies (e.g., syringes, blood tubes, gloves), and educational supplies (e.g., brochures, videos).

Contractual: Provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. List both patient care (e.g., laboratory) and non-patient care (e.g., janitorial) contracts. Each grantee is responsible

for ensuring that its organization/institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring contracts.

Other: Include all costs that do not fit into any other category and provide an explanation of each cost (e.g., audit, legal counsel). In some cases, rent, utilities, organizational membership fees, and insurance fall under this category if they are not included in an approved indirect cost rate. This category can also include the cost of access accommodations, including sign language interpreters, plain language materials, health-related print materials in alternate formats (e.g., Braille, large print), and cultural/linguistic competence modifications (e.g., use of cultural brokers, translation, or interpretation services at meetings, clinical visits, and conferences).

Indirect Charges: Costs incurred for common or joint objectives that cannot be readily identified but are necessary to organizational operation (e.g., facility operation and maintenance, depreciation, administrative salaries). Visit <https://rates.psc.gov> to learn more about rate agreements, including the process for applying for them.

APPENDIX A: PROGRAM SPECIFIC FORMS INSTRUCTIONS

FORM: Federal Object Class Categories (Required)

This form will collect details about the federal section 330 grant request and the total non-federal (non-section 330) funding for the upcoming budget period. This information will enable HRSA to review the proposed use of federal grant dollars to ensure that all applicable requirements described in 45 CFR 74 or 45 CFR 92 are met.

In the Total Proposed Budget section, the federal section 330 funding request and the total non-federal (non-section 330) funding amounts will pre-populate from the total column of Section A of the Budget Information: Budget Details form. If the pre-populated values are incorrect, adjustments must be made in Section A (Budget Summary) of the Budget Information: Budget Details form.

In the Budget Categories section, break down the federal section 330 funding request and non-federal funds by the object class categories (see the [Budget Narrative](#) section for details). The Total column should match the equivalent Total column in Section B of Budget Information: Budget Details form. Fields cannot be left blank; enter zeros as necessary.

FORM 2: Staffing Profile (Required)

Report personnel salaries supported by the total budget and federal request (i.e., requested Health Center Program federal dollars) for the **upcoming 12-month budget period**, including those that are part of an indirect cost rate. Include Health Center Program staff only for the entire scope of project (i.e., all sites).

- Salaries in categories representing multiple positions (e.g., LPN, RN) must be averaged. To calculate the average annual salary, sum the salaries within the category and divide that amount by the total number of FTEs.
- Do not report portions of salaries that support activities outside the proposed scope of project.
- Do not include contracted staff or volunteers on this form.

When completing each section of the form, use the Save and Calculate Total Salary button in each section to populate the Total Salary column and save all values entered in the section. Fields cannot be left blank; enter zeros as necessary.

Note: The amount for total salaries (use the Calculate button in EHB) may not match the amount allocated for the Personnel object class category of the Budget Information: Budget Details Form due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3: Income Analysis (Required)

Form 3 will show the projected patient services and other income from all sources (other than the section 330 federal grant) for the **upcoming 12-month budget period**. Form 3 income is divided into two parts: (1) program income (known as patient service revenue) and (2) all other income.

Patient service revenue is revenue that is directly tied to the provision of services to the health center's patients. Services to patients that are reimbursed by health insurance plans, managed care organizations (MCOs), categorical grant programs (e.g., family planning), employers, and health provider organizations are classified as patient service revenue. Reimbursements may be based upon visits, procedures, member months, enrollees, the achievement of performance goals, or other service related measures. All income not classifiable as program income is classified as other income.

Please note that in-kind donations are not included as income on Form 3.

Part 1: Program Income

The program income section groups billable visits and income into the same five payer groupings used in the Uniform Data System (UDS – see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics> for details). All patient service revenue is reported in this section of the form. This includes all income from medical, dental, behavioral health, substance abuse, other professional, vision, and other clinical services as well as income from ancillary services such as laboratory, pharmacy, and imaging services.

Patient service revenue includes income earned from Medicaid and Medicare rate settlements and wrap reconciliations which are designed to make up the difference between the approved FQHC rate and the interim amounts received. It includes risk pool and other incentive income as well as primary care case management fees.

Patient service revenue associated with sites or services not in the approved scope of project including those pending approval is to be excluded.

Column (a) Patients: These are the projected number of unduplicated patients classified by payer based upon the patient's **primary medical insurance**. The primary insurance is the payer that is billed first. The patients are classified in the same way as found in UDS Table 4, lines 7 – 12. This column should not include patients who are only seen for non-billable or enabling service visits. Examples for determining where to count patients include:

- A crossover patient with Medicare and Medicaid coverage is to be classified as a Medicare patient on line 2.
- A Medicaid patient with no dental coverage who is only seen for dental services is to be classified as a Medicaid patient on line 1 with a self-pay visit on line 5.

Column (b): Billable Visits: These include all billable/reimbursable visits.² There may be other exclusions or additions which, if significant, should be noted in the Comment/Explanatory Notes box at the bottom of the form. Billable services related to laboratory, pharmacy, imaging, and other ancillary services are not to be included in this column (see [ancillary instructions](#) below).

Column (c): Income per Visit: This is the quotient arrived at by dividing projected income by billable visits.

Column (d): Projected Income: This is the projected accrued net revenue, including an allowance for bad debt from all patient services for each pay grouping in the upcoming 12-month budget period.

Column (e): Prior FY Income Mo/Yr.: This is the income data from the most recent fiscal year, which will be either interim statement data or audit data. The fiscal year was specified because the interim data can eventually be compared to actual audit data.

(Lines 1 – 5) Payer Categories: There are five payer categories including Medicaid, Medicare, Other Public, Private, and Self-Pay, reflecting the five payer groupings used in Table 9d of the UDS. The UDS instructions are to be used to define each payer category (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/index.html>).

Visits are reported on the line of the primary payer (payer billed first). The income is classified by the payer groupings where the income is earned. When a single visit involves more than one payer, attribute that portion of the visit income to the payer group from which it is earned. In cases where there are deductibles and co-payments to be paid by the patient, that income is to be shown on the self-pay line. If the co-payment is to be paid by another payer, that income should be shown on the other payer's line. It is acceptable if the applicant cannot accurately associate the income to secondary and subsequent sources.

All service income is to be classified by payer, including pharmacy and other ancillary service revenue. In the event the applicant does not normally classify the projected ancillary or other service revenue by payer category, the projected income is to be allocated by payer group using a reasonable allocation method, such as the proportion of medical visits or charges. The method used should be noted in the Comments/Explanatory Notes section at the bottom of the form.

(Line 1) Medicaid: This includes income from FQHC cost reimbursement; capitated managed care; fee-for-service managed care; Early Periodic Screening, Diagnosis, and Treatment (EPSDT); Children's Health Insurance Program (CHIP); and other reimbursement arrangements administered either directly by the state agency or by a fiscal intermediary. It includes all projected income from managed care capitation,

² These visits will correspond closely with the visits reported on the UDS Table 5, excluding enabling service visits.

settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

(Line 2) Medicare: This includes income from the FQHC cost reimbursement, capitated managed care, fee-for-service managed care, Medicare Advantage plans, and other reimbursement arrangements administered either directly by Medicare or by a fiscal intermediary. It includes all projected income from managed care capitation, settlements from the FQHC cost reimbursement, risk pool distributions, performance incentives, and care management fee income from the ACA Medicare Demonstration Program.

(Line 3) Other Public: This includes income from federal, state, or local government programs earned for providing services that is not reported elsewhere. A CHIP operated independently from the Medicaid program is an example of other public insurance. Other public also includes income from categorical grant programs when the grant income is earned by providing services. Examples of these include CDC's National Breast and Cervical Cancer Early Detection Program and the Title X Family Planning Program.

(Line 4) Private: This includes income from private insurance plans, managed care plans, insurance plans from the ACA marketplaces/exchanges, and other private contracts for service. This includes plans such as Blue Cross and Blue Shield, commercial insurance, managed care plans, self-insured employer plans, group contracts with unions and employers, and service contracts with employers. Income from health benefit plans which are earned by government employees, retirees, and dependents, such as TRICARE, the federal employee health benefits program, state employee health insurance benefit programs, teacher health insurance, and similar plans are to be classified as private insurance. Private insurance is earned or paid for by the beneficiary and other public insurance is unearned or based upon meeting the plan's eligibility criteria.

(Line 5) Self-Pay: This includes income from patients, including full-pay self-pay and sliding fee patients, as well as the portion of the visit income for which an insured patient is personally responsible.

(Line 6) Total: This is the sum of lines 1-5.

Part 2: Other Income

This section includes all income other than the patient service revenue shown in Part 1 (exclusive of the section 330 grant request). It includes other federal, state, local, and other income. It is income that is earned but not directly tied to providing visits, procedures, or other specific services. Income is to be classified on the lines below based upon the source from whom the revenue is received. Income from services provided to non-health center patients (patients of an entity with which the health center is contracting) either in-house or under contract with another entity such as a hospital, nursing home or other health center is to be reported in Part 2: Other Income (see examples below). This would include income from in-house retail pharmacy sales to

individuals who are not patients of the health center. See Lines 9 and 10 for examples of services provided to non-health center patients (patients of an entity with which the health center is contracting).

(Line 7) Other Federal: This is income from federal grants where you are the recipient of a Notice of Award from a federal agency. It does not include the section 330 grant request or federal funds awarded through intermediaries (see Line 9 below). It includes grants from federal sources such as the Centers for Disease Control (CDC), Housing and Urban Development (HUD), Centers for Medicaid and Medicare Services (CMS), and others.

(Line 8) State Government: This is income from state government grants, contracts, and programs, including uncompensated care grants; emergency preparedness grants; mortgage assistance; capital improvement grants; school health grants; Women, Infants, and Children (WIC); immunization grants; and similar awards.

(Line 9) Local Government: This is income from local government grants, contracts, and programs, including indigent care grants, community development block grants, capital improvement project grants, and similar awards. For example: (1) a health center that contracts with the local Department of Health to provide services to the Department's patients is to report all the income earned under this contract on this line, and (2) Ryan White Part A funds are federal funds awarded to municipalities who in turn make awards to provider organizations, so Ryan White Part A grants would be classified as income earned from a local government and be shown on this line.

(Line 10) Private Grants/Contracts: This is income from private sources such as foundations, non-profit entities, hospitals, nursing homes, drug companies, employers, other health centers, and similar entities. For example, a health center operating a 340B pharmacy in part for its own patients and in part as a contractor to another health center is to report the pharmacy income for its own patients in Part 1 and the income from the contracted health center on this line.

(Line 11) Contributions: This is income from private entities and individual donors which may be the result of fund raising.

(Line 12) Other: This is incidental income not reported elsewhere and includes items such as interest income, patient record fees, vending machine income, dues, and rental income. Grantees typically have at least some income to report on Line 12.

(Line 13) Applicant (Retained Earnings): This is the amount of funds needed from the applicant's retained earnings or reserves in order to achieve a breakeven budget. Explain in the Comments/Explanatory notes section why the applicant funds are needed and provide an assurance that the reserves are sufficient to meet the amount budgeted and that the remaining reserves are adequate to support normal operations.

(Line 14) Total Other: This is the sum of lines 7 – 13.

(Line 15) Total Non-Federal: This is the sum of Lines 6 and 14 and is the total non-federal (non-section 330) income. When this value is added to the section 330 grant, the total equals the applicant's total budget for the the upcoming 12-month budget period.

FORMS 5A, 5B, and 5: Scope of Project (Informational/Read-Only)

Data will be pre-populated from the grantee's official scope of project and **CANNOT** be modified. Only services, sites, and other activities/locations included on Forms 5A, 5B, and 5C respectively are considered to be in a grantee's approved scope of project. Use the Refresh from Scope button to update the BPR with data from your current approved scope of project.

If current services provided/service sites/other activities/locations do not match what is pre-populated, contact your Project Officer regarding initiating a change in scope request. Some changes (e.g., service area census tracts, service area zip codes (service site only), Medicare/Medicaid billing numbers) can be made to your scope of project via self-update in EHB. Refer to the Scope of Project documents at <http://bphc.hrsa.gov/policiesregulations/policies> for additional information.