

**Instructions for Preparing and Submitting the FY 2015
Health Center Program (H80) Budget Period Progress Report (BPR)
Non-Competing Continuation (NCC)**

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TABLE 1: SUBMISSION SCHEDULE

Budget Period Start Date	EHB Access to Submission	EHB Deadline (5:00 PM ET)
November 1, 2014	July 10, 2014	August 13, 2014
December 1, 2014	July 16, 2014	August 27, 2014
January 1, 2015	August 6, 2014	September 17, 2014
February 1, 2015	September 3, 2014	October 15, 2014
March 1, 2015	October 8, 2014	November 19, 2014
April 1, 2015	October 29, 2014	December 17, 2014
May 1, 2015	December 3, 2014	January 28, 2015
June 1, 2015	January 7, 2015	February 18, 2015

FY 2015 BPR Instructions updated on July 24, 2014

FY 2015 BPR Summary of Changes As Compared to FY 2014

- [The Patient Capacity table](#) in the Program Narrative Update section includes three new columns of pre-populated information to facilitate progress reporting: % Change 2011-2013 Trend; % Change 2011-2013; and % Progress Toward Goal. Additionally, the grantee's project period was added to the table to provide a reference point for the progress narrative.
- [The Supplemental Awards table](#) in the Program Narrative Update section has been updated to reflect the most current list of supplemental awards for grantees and includes a new Numeric Progress Toward Goal column.
- [The Performance Measures table](#) in the Program Narrative Update section includes three new measures (Tobacco Use Screening and Cessation, Newly Identified HIV Cases with Timely Follow Up, and Depression Screening and Follow Up). For details, refer to Program Assistance Letter [PAL 2014-01](#). Additionally, the Behavioral Health measure included in the "Other Measures" category is no longer required.
- [Form 3: Income Analysis](#) has been programmed into the Program Specific Forms section and should be completed online in EHB rather than uploaded as an attachment.
- A [Scope Verification summary page](#) has been added requesting scope of project certifications for Form 5A: Services and Form 5B: Services Sites.
- [The Budget Information: Budget Details](#) form has been modified to capture federal and non-federal funding in the Object Class Categories section.
- The Federal Object Class Categories form has been removed.

This Budget Period Progress Report (BPR) non-competing continuation will provide funding for the FY 2015 budget year (budget periods starting November 1, 2014 – June 1, 2015).

I. TECHNICAL ASSISTANCE

The BPR technical assistance website is available at <http://bphc.hrsa.gov/policiesregulations/continuation>. The website includes copies of forms, the EHB user guide, frequently asked questions (FAQs), and a slide presentation.

Technical assistance regarding business, administrative, or fiscal issues is available 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
Office of Policy and Program Development
HRSA Bureau of Primary Health Care
301-594-4300
BPFCBPR@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 BPFCHelpline@hrsa.gov.

II. GENERAL INSTRUCTIONS

Progress reports lacking all required documents and information will be 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 information or clarification. **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.** Grantees should carefully review their BPR to ensure it is both complete and responsive prior to submission.

Significant budget revisions or changes to the project (e.g., change in Project Director/CEO, change in scope of project) must be requested via the Prior Approval Module or Change in Scope (CIS) Module in EHB, as appropriate. 45 CFR 74.25 defines the rules governing when rebudgeting among the federal object budget class categories requires prior HRSA approval. Specifically, grantees must seek prior approval from HRSA when proposing to shift Health Center Program grant funds between the federal object class budget categories above the specified threshold. 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 [Table 2](#), the word “Form” refers to forms that are completed online through EHB. The word “Document” refers to materials that must be uploaded into EHB. The word “Fixed” refers to forms that cannot be altered but may be refreshed from scope. [Appendix A](#) provides detailed instructions on the required forms and documents.

TABLE 2: SUBMISSION COMPONENTS

- All items noted below are required.
- Refer to [Appendix A](#) for detailed instructions on completing the forms listed below, unless otherwise noted.
- The Budget Narrative is the only document that counts against the page limit.
- Form samples (except the SF-PPR and SF-PPR-2 and Forms 5A, 5B, and 5C) are available at <http://bphc.hrsa.gov/policiesregulations/continuation>.

Progress Report Section	Form Type	Instructions
SF-PPR and SF-PPR-2	Form	Refer to instructions in the BPR EHB user guide available at http://bphc.hrsa.gov/policiesregulations/continuation .
Budget Information: Budget Details	Form	Refer to Section IV for detailed instructions.
Budget Narrative	Document	Upload the Budget Narrative. This attachment can be no longer than 40 pages (approximately 5 MB). Refer to Section IV for detailed instructions. A sample budget narrative is available at http://bphc.hrsa.gov/policiesregulations/continuation .
Form 2	Form	List staffing for the upcoming budget period.
Form 3	Form	Provide projected program income for the upcoming budget period.
Forms 5A, 5B, and 5C	Fixed	These forms are pre-populated to reflect the current scope of project. Changes must be requested via Change in Scope (CIS) request or self-update. Contact your Project Officer for guidance.
Scope Verification	Form	Certify that the sites and services in scope are accurate or that a CIS request or self-update has been initiated to correct inaccurate information. Contact your Project Officer for guidance.
Program Narrative Update	Form	Refer to Section III for instructions.

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 2015 budget period. Respond to each item below and ensure consistency between the Program Narrative Update and other components of the BPR submission.

Describe the following for the FY 2014 budget period and any predicted changes for the FY 2015 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
 - Operations
 - Systems, including financial, clinical, and/or practice management systems
 - Financial status
- 3. Patient Capacity (3,000 characters = approximately 1 page):** See [Table 3: Patient Capacity table](#). 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 key factors driving significant changes in patient numbers. Maintenance or increases in patient numbers are expected; decreasing trends or limited progress towards the projected patient goals must be explained.

New in 2015: The Patient Capacity table includes the grantee's project period and three additional columns of pre-populated information to facilitate narrative progress reporting (% Change 2011-2013 Trend, % Change 2011-2013, and % Progress Toward Goal).
- 4. Supplemental Awards (3,000 character limits = approximately 1 page):** See [Table 4: Supplemental Awards](#). Discuss progress made in implementing recent supplemental Health Center Program awards. For each of the supplemental awards, as applicable, provide current data in the Numeric Progress Toward Goal column that corresponds to the narrative. In the Supplemental Award Narrative column, describe:
 - a. Progress toward goals;
 - b. Key contributing and restricting factors impacting progress toward goals; and
 - c. Plans for sustaining progress and/or overcoming barriers to ensure goal achievement.

New in 2015: The Supplemental Awards table includes a new Numeric Progress Toward Goal column to facilitate reporting numeric progress, as applicable.

5. Clinical/Financial Performance Measures (3,000 characters = approximately 1 page): See [Table 5: Performance Measures](#). Referencing the % Change 2011-2013 Trend, % Change 2012-2013, and % Progress Toward Goal columns, 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. Maintenance or improvement in performance is expected; decreasing trends or limited progress towards the projected goals must be explained.

New in 2015: HRSA added two new clinical performance measures (*Depression Screening and Follow Up* and *New HIV Cases with Timely Follow Up*), merged two tobacco performance measures (new measure *Tobacco Use Screening and Cessation*), and removed the *Other – Behavioral Health* measure requirement. For more details on the new measures, refer to [PAL 2014-01](#).

- **Depression Screening and Follow Up:** Percentage of patients aged 12 and older screened for clinical depression using an age appropriate standardized tool AND follow-up plan documented.
- **New HIV Cases with Timely Follow Up:** Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.
- **Tobacco Use Screening and Cessation:** Percentage of patients age 18 years and older who were screened for tobacco use at least once during the measurement year or prior year AND who received cessation counseling intervention and/or pharmacotherapy if identified as a tobacco user. This measure is a combination of the previous Tobacco Use Assessment and Tobacco Cessation Counseling performance measures.
- **Other – Behavioral Health:** The previously self-defined Other – Behavioral Health measure is no longer required due to the addition of the Depression Screening and Follow-Up measure.

TABLE 3: PATIENT CAPACITY

	2011 Patient Number	2012 Patient Number	2013 Patient Number	Projected Number of Patients*	% Change 2011-2013 Trend	% Change 2012-2013	% Progress Toward Goal	Patient Capacity Narrative
Project Period: (Pre-populated from most recent Notice of Award)								
Total Unduplicated Patients (inclusive of the categories below)	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from 2013 UDS	Pre-populated from the application that initiated the current budget period	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	3,000 character limit
Total Migratory and Seasonal Agricultural Worker Patients	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from 2013 UDS	Pre-populated from the application that initiated the current budget period	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	3,000 character limit
Total People Experiencing Homelessness Patients	Pre-populated from 2011 UDS	Pre-populated from 2012 UDS	Pre-populated from 2013 UDS	Pre-populated from the application that initiated the current budget period	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	3,000 character limit
Total Public Housing Resident Patients**	Pre-populated from 2014 BPR	Pre-populated from 2014 BPR	No pre-populated data	Pre-populated from the application that initiated the current budget period	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	3,000 character limit
Notes: <ul style="list-style-type: none"> (*) The Projected Number of Patients column is pre-populated from the application/submission that initiated your current budget period (SAC/NAP/BPR). If you were awarded an FY 2013 or FY 2014 New Access Point (NAP) satellite grant or an FY 2014 Expanded Services (ES) supplemental funding, the patient projection in your NAP and/or ES application has been added to the projection from the application/submission that initiated your current budget period (SAC/NAP/BPR). If pre-populated patient projections are not accurate, provide adjusted projections and explain (e.g., overall patient projection has increased due to Expanded Services supplemental funding) in the Patient Capacity Narrative section. % Change and % Progress data are pre-populated calculations based on UDS reporting. (**) Patient data are pre-populated from Table 4 in the UDS Report. Since public housing patients will not be included in this table until CY 2014 UDS reporting, these data are pre-populated from the FY 2014 BPR. Provide FY 2013 public housing patient numbers from your health center data, if applicable 								

TABLE 4: SUPPLEMENTAL AWARDS

	Programmatic Goal	Numeric Goal	Numeric Progress Toward Goal	Supplemental Award Narrative
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	As applicable	3,000 character limit
FY 2013 NAP Satellite Grant	Achieve operational status, and increase number of patients	Pre-populated with end of project period patient projection	As applicable	3,000 character limit
FY 2014 NAP Satellite Grant	Achieve operational status, and increase number of patients	Pre-populated with end of project period patient projection	As applicable	3,000 character limit
FY 2014 Behavioral Health Integration (BHI) Supplement	Increase the number of patients with access to integrated behavioral health care	Pre-populated with the number of new patients to receive integrated behavioral health care	As applicable	3,000 character limit
FY 2014 Expanded Services (ES) Supplement	Increase the number of patients and expand availability of services	Pre-populate with the number of new patients to receive expanded services (across all projects)	As applicable	3,000 character limit

TABLE 5: PERFORMANCE MEASURES

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Perinatal Health								
Access to prenatal care in 1st trimester	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit
Low birth weight (< 2500 grams)	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Preventive Health Screenings and Services								
Weight assessment and counseling for children and adolescents	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Adult weight screening and follow up	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Tobacco Use Screening and Cessation	No data available	No data available	No data available	No data available	No data available	No data available	Grantee to establish goal	
Colorectal cancer screening	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Cervical cancer screening	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Childhood immunizations by 3rd birthday	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Chronic Disease Management								
Asthma treatment – pharmacologic therapy	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Coronary artery disease (CAD) and lipid-lowering therapy	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Ischemic Vascular Disease (IVD) and aspirin or other anti-thrombotic therapy	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Blood pressure control	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Diabetes control	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
New HIV Cases With Timely Follow Up	No data available	No data available	No data available	No data available	No data available	No data available	Grantee to establish goal	
Depression Screening and Follow Up	No data available	No data available	No data available	No data available	No data available	No data available	Grantee to establish goal	
Financial Measures								
Total cost per patient	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	3,000 character limit
Medical cost per medical visit	Pre-populated from 2011 UDS (if available)	Pre-populated from 2012 UDS (if available)	Pre-populated from 2013 UDS (if available)	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Change in Net Assets to Expense Ratio*	Pre-populated from 2011 audit data (if available)	Pre-populated from 2012 audit data (if available)	Provide data if available	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Long Term Debt to Equity Ratio*	Pre-populated from 2011 audit data (if available)	Pre-populated from 2012 audit data (if available)	Provide data if available	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Working Capital to Monthly Expense Ratio*	Pre-populated from 2011 audit data (if available)	Pre-populated from 2012 audit data (if available)	Provide data if available	Pre-populated calculation	Pre-populated calculation	Pre-populated calculation	Pre-populated from the application that initiated the current budget period	
Other Measures								
Oral Health	Provide data if available	Provide data if available	Provide data if available	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated from the application that initiated the current budget period	3,000 character limit

	2011 Measures	2012 Measures	2013 Measures	% Change 2011-2013 Trend	% Change 2012-2013	% Progress toward Goal	Measure Goals	Measure Narrative
Other Measures (if applicable)	Provide data if available	Provide data if available	Provide data if available	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated calculation (if data are provided)	Pre-populated from the application that initiated the current budget period	
Notes: <ul style="list-style-type: none"> • If pre-populated performance measure goals are not accurate, provide adjusted goals and explain (e.g., goal for the diabetes measure has increased based on improved patient tracking via a new EHR) in the appropriate Measure Narrative section. • Measure goals are pre-populated from the Projected Data (by End of Project Period)/Measure Goal from your FY 2014 SAC/NAP/BPR. • For measures with no projected data provided in the FY 2014 SAC/NAP/BPR, provide a percentage goal for the end of the project period. • (*) Does not apply to Tribal or public entities. 								

Refer to the following resources for assistance with analyzing performance measure progress:

- UDS Reporting Manual: <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2013udsreport.pdf>
- UDS TA Site: <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting>

IV. BUDGET PRESENTATION INSTRUCTIONS

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

In the formulation of your budget presentation, per section 330(e)(5)(A) of the Public Health Service (PHS) Act (42 U.S.C. 254b), the amount of grant funds awarded 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. Health Center Program grant funds are to be used for authorized health center operations and may not be used for profit or to support other lines of business. Further, as stated in section 330 of the PHS Act, the federal cost principles apply only to federal grant funds.

The total budget represents projected operational costs for the health center scope of project where all proposed expenditures directly relate to and support in-scope activities. The total budget is inclusive of Health Center Program grant funds and non-grant funds, which includes both program income and all other non-Health Center Program grant funding sources. Therefore, the total budget must reflect projections from all anticipated program income revenue sources (e.g., fees, premiums, third-party reimbursements, payments) generated from the delivery of services and from other non-Health Center Program grant sources such as state, local, or other federal grants or contracts, private contributions, and income generated from fundraising. For additional guidance on budgeting, accounting, and use of Health Center Program grant and other non-grant funds, see [PIN 2013-01](#).

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.

NEW for FY 2015: The Budget Information: Budget Details form has been modified to enable the capture of federal and non-federal funding in the Object Class Categories section. The Federal Object Class Categories form has been removed.

A. Budget Information: Budget Details Form

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 should correspond with the recommended future support figure (Item 13 or Box 13) 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**, provide the Health Center Program federal funding request in the first column and the non-federal funding in the second column by object class category. Each line represents a distinct object class category that must be addressed in the budget narrative.

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, leave the State column blank and include State funding in the Applicant column. Note that Program Income must be consistent with the Total Program Income presented in [Form 3](#) – Income Analysis.

Salary Limitation

Provisions enacted in the Consolidated Appropriations Act, 2014 (P.L. 112-74) continue in 2015. The Consolidated Appropriations Act, 2014 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 \$181,500). 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 \$181,500 plus fringe benefits of 25 percent (\$45,375). This results in a total of \$113,437 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 6: 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: \$181,500 (50% of time will be devoted to the project).	
Direct Salary	\$90,750
Fringe (25% of salary)	\$22,687
Total	\$113,437

B. Budget Narrative

The budget narrative must detail the costs of each line item within each object class category from the Budget Information: Budget Details form – federal section 330 request and non-federal (non-section 330) funding. The budget narrative 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 of Section B: Budget Categories of the Budget Information: Budget Details form. The budget narrative 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 most recent 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. Ensure that the budget narrative 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/hhsgrantspolicy.pdf> for information on allowable costs.

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

Personnel Costs: Personnel costs must be explained by listing the exact amount requested for the upcoming budget period. **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 \$181,500.¹ 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 the Health Center Program grant. Provide all base salaries at the full amount even if they exceed the salary limit.

See Table 7 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 7: BUDGET SAMPLE FOR SALARY LIMITATION

Name	Position Title	% of FTE	Base Salary	Adjusted Annual Salary	Federal Amount Requested
J. Smith	Physician	50	\$225,000	\$181,500	\$90,750
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 \$5,000.

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.,

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 \$181,500.

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 2 – Staffing Profile

Report personnel salaries supported by the total budget and federal request (i.e., requested Health Center Program (section 330) funds) for the **upcoming 12-month budget period**, including those that are part of an indirect cost rate. Include health center staff for the entire scope of project (i.e., across all sites).

- Allocate staff time by function among the staff positions listed. For example, list a provider serving as a part-time family physician and a part-time Chief Medical Officer (CMO) in each respective category with the FTE percentage allocated to each position (e.g., CMO 30% FTE and family physician 70% FTE). Do not exceed 100% FTE for any individual. For position descriptions, refer to the UDS manual at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting>.
- Provide average salaries in categories representing multiple positions (e.g., LPN, RN). 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.

Note: The amount for total salaries (this figure will auto-calculate in EHB) may not match the amount allocated for the Personnel cost category of the Budget Summary Form due to the inclusion of salaries charged to indirect costs on the Staffing Profile.

FORM 3 – Income Analysis

Form 3 will show the projected patient services and other income from all sources (other than the Health Center Program grant) for the **upcoming 12-month budget period**. Form 3 income is divided into two parts: (1) program income (i.e., patient service revenue) and (2) all other income (i.e., other federal, state, local, and 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, 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.

New in 2015: Form 3: Income Analysis has been programmed into the Program Specific Forms section and should be completed online in EHB rather than uploaded as an attachment.

Part 1: Patient Service Revenue - Program Income

The program income section groups billable visits and income into the same five payer groupings used in the UDS (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting> for details). All patient service

revenue is reported in this section of the form. This includes all income from medical, dental, mental 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 that 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.

Patients by Primary Medical Insurance - Column (a): 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.

Billable Visits - Column (b): 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).

Income per Visit - Column (c): This value may be calculated by dividing projected income by billable visits.

Projected Income - Column (d): 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.

Prior FY Income: 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.

Payer Categories (Lines 1 – 5): 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

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

category (see the UDS Manual available at <http://bphc.hrsa.gov/healthcenterdatastatistics/reporting>).

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.

Medicaid (Line 1): 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, settlements from FQHC cost reimbursement reconciliations, wrap payments, incentives, and primary care case management income.

Medicare (Line 2): 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 Affordable Care Act (ACA) Medicare Demonstration Program.

Other Public (Line 3): 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.

Private (Line 4): 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, service contracts with employers, and Veteran's Administration Community Based Outpatient Clinic (CBOC) contracts. Income from health benefit plans which are earned by government employees, veterans, 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.

Self-Pay (Line 5): 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.

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

Part 2: Other Income – Other Federal, State, Local, and 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).

Other Federal (Line 7): This is income from federal grants where the applicant is 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 and Prevention (CDC), Housing and Urban Development (HUD), Centers for Medicare and Medicaid Services (CMS), and others. It includes Health and Human Service (HHS) grants under the Ryan White Part C Program; Affordable Care Act health center capital grants; and others. The CMS Medicare and Medicaid electronic health record incentive program income is reported here in order to be consistent with the UDS reporting instructions.

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

Local Government (Line 9): This is income from local government grants, contracts, and programs, including local indigent care income, 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.

Private Grants/Contracts (Line 10): 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.

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

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

Applicant (Retained Earnings) (Line 13): 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 applicant funds (retained earnings) are needed to achieve a breakeven budget. Amounts from non-federal sources, combined with the Health Center Program funds, should be adequate to support normal operations.

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

Total Non-Federal (Line 15): This is the sum of Lines 6 and 14 and is the total non-federal (non-section 330) income.

Note: In-kind donations are not included as income on Form 3.

FORMS 5A: Services, 5B: Service Sites, and 5C: Other Activities/Locations – Scope of Project

Only services, sites, and other activities/locations included on Forms 5A, 5B, and 5C respectively are included in a grantee's approved scope of project. Data will be pre-populated from the grantee official scope of project and cannot be modified. If the pre-populated data does not reflect recent scope changes, click the [Refresh from Scope](#) button to update scope data in the BPR.

VERIFICATION FORM – Scope Verification summary page

This form requires two certifications. First, certify that the scope of project for services (including service delivery methods) is accurate, as presented on Form 5A: Services in the BPR. Second, certify that the scope of project for sites (including service area zip codes) is accurate, as presented on Form 5B: Service Sites in the BPR. **If you cannot certify the accuracy of Form 5A and/or Form 5B, you must certify that you have submitted a CIS request to HRSA to correct the presented information.**

Note: If the information presented in the BPR on Forms 5A and 5B is not accurate after it has been refreshed, you must take action to correct this information **before** BPR submission. Review the resources at <http://bphc.hrsa.gov/about/requirements/scope>. Contact your Project Officer for additional assistance.