



COLORADO

Department of Health Care
Policy & Financing

**COLORADO DEPARTMENT OF
HEALTH CARE POLICY AND FINANCING
MEDICAL ASSISTANCE PROGRAM**

**MEDICAID COST REPORT INSTRUCTIONS FOR
FEDERALLY QUALIFIED HEALTH CENTERS**

EFFECTIVE DATE

JANUARY 1, 2020

In circumstances where the State of Colorado rules are revised subsequent to this effective date, the rules adopted by the State of Colorado will supersede the guidance in this manual.

TABLE OF CONTENTS

INTRODUCTION	3
STATISTICAL DATA/CERTIFICATION FORM	9
WORKSHEET 1	10
WORKSHEET 1 – SUPPLEMENT 1	26
WORKSHEET 1 – SUPPLEMENT 2	28
WORKSHEET 2.....	32
WORKSHEET 3.....	35
WORKSHEET 4.....	39
ADDENDUM 1	42
ADDENDUM 2	44
ADDENDUM 3	46
APPENDIX A.....	47
APPENDIX B	67
APPENDIX C	71
APPENDIX D.....	79
APPENDIX E	80

INTRODUCTION

Medical Assistance Programs and Federally Qualified Health Centers

The Federal government grants funding to states, including the State of Colorado, through the Medicaid program for the purpose of providing medical assistance programs on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services (Section 1901 of the Social Security Act).

A Federally Qualified Health Center (FQHC) is an entity which receives a grant under Section 330 of the Public Health Service Act (Section 1905(1)(2)(B) of the Social Security Act). Those designated as FQHC look-alikes are treated as FQHCs for Medicaid program purposes. The State of Colorado contracts with FQHCs to provide medical services to patients who are determined to be Medicaid beneficiaries. An FQHC can be either hospital-based or freestanding; this manual pertains to both. The State of Colorado is required to make payment for FQHC services at 100% of the costs, which are reasonable and related to the cost of furnishing medical services, to ensure that federal Public Health Service Act grant funds are not used to subsidize health center or program services to Medicaid beneficiaries.

FQHC costs related to medical services provided must be allowable, allocable, reasonable and given consistent treatment within the accounting records. Medical services provided include general services for outpatient primary care, emergency services, and services provided through agreements or arrangements, such as physician services or additional and specialized diagnostic and laboratory services not available at the FQHC (10 CCR 2505-10 8.700.3). Allowable costs include compensation of provider staff, costs of services and supplies related to services delivered by provider staff, overhead costs and costs of services purchased by the FQHC (10 CCR 2505-10 8.700.5.A). Unallowable costs include, but are not limited to, expenses incurred by an FQHC that are not for the provision of covered services, according to the laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per-visit encounter rate for Medicaid clients (10 CCR 2505-10 8.700.5.B).

Reimbursement and Rate Calculation

FQHCs shall be reimbursed a per-visit encounter rate based on 100% of reasonable cost. An FQHC may be reimbursed for up to three separate encounters for one individual occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following:

- ✓ Physical health encounter
- ✓ Dental encounter
- ✓ Specialty behavioral health encounter

Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited. Effective July 1, 2018, FQHCs shall be reimbursed directly by the Colorado Department of Health Care Policy and Financing (Department) for up to six (6) sessions of Short Term Behavioral Health services at the specialty behavioral health encounter rate. The following procedure codes are included as Short Term Behavioral Health services: 90791, 90832, 90834, 90837, 90846, 90847.

A distinct specialty behavioral health encounter is generated when:

- a. Rendered services are included in the six sessions of Short Term Behavioral Health services reimbursed directly by the Department, or
- b. The services are covered by a contracted Regional Accountable Entity (RAE). Services covered by the RAE may be found [here](#).

The costs and visits for behavioral health services (procedure codes) covered by the RAE or under Short Term Behavioral Health services are classified as specialty behavioral health. Neither payer nor billing status are considered in determining whether an encounter is classified in the specialty behavioral health rate. Rather, classification of behavioral health costs and visits is determined by the service (procedure code) provided.

The costs and visits associated with any other behavioral health services, such as Evaluation and Management codes with behavioral health diagnoses, are included in the physical health rate.

“Visit” means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker. Group sessions do not generate a billable encounter for any FQHC services (10 CCR 2505-10 8.700.1). Effective July 1, 2018, the definition of a visit was expanded to include encounters with licensed marriage and family therapists, licensed professional counselors and licensed addiction counselors, in addition to the providers previously listed. The costs for services delivered by these providers are included as covered health care costs on the cost report and the related visits cannot be billed in any other manner than via the annually established encounter rate. There may be Medicaid-covered services that are delivered by a provider not listed above. If so, these costs are also included in the cost report, even though there is no billable encounter.

After the cost report has been finalized, the Department of Health Care Policy and Financing and their cost report auditor (contractor) will calculate the new Prospective Payment System (PPS) and Alternative Payment Method (APM) rates. Effective July 1, 2018, along with an all-inclusive APM rate, a separate APM rate will be calculated for physical health, dental health, and specialty behavioral health services. The final APM rates will be the lower of the rates calculated from the current year cost/visit data and the base rates. Base rates will be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial base rates shall be calculated when the Department has two year’s data of costs and visits. The final encounter rates shall be APM rates. In the event that the PPS rate is greater than the calculated all-inclusive APM rate, there will be a process to reconcile final reimbursement to the PPS rate.

Final approval of the cost report is communicated to the FQHC in writing. The letter includes the final approved encounter rates and effective date, a description of the appeal process, and the detail of the FQHC base rates, APM rates, and PPS rate calculations. The letter also includes scope of service rate adjustment determination, if applicable. The FQHC then must complete the Payment Methodology Agreement by either selecting their APM rates or PPS rates. This form must be completed and returned to Myers & Stauffer.

The new encounter rate shall be effective 120 days after the FQHC’s fiscal year end if it is less than the

old encounter rate. However, if the new encounter rate is greater than the old encounter rate, the old encounter rate shall remain in effect for an additional day above the 120 day limit for each day the cost report package is submitted late (10 CCR 2505-10 8.700.6.D). The cost report package is described in the Cost Report Forms section of these instructions.

General Cost Reporting Principles

FQHCs should follow these overarching principles when preparing the cost report:

- 1) The cost report must reflect the same fiscal period as the audited financial statements.
- 2) Total expenses on the cost report must reconcile with the FQHC's audited financial statements.
- 3) All costs must be reported on the accrual basis of accounting and only costs for the reporting period may be included; costs from other periods are unallowable.
- 4) Allowable costs are those that are reasonable and associated with providing services that are defined in [Colorado's Medicaid State Plan](#), in the FQHC's HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#). They include costs directly or indirectly tied to patient care, and those costs related to increasing access for the Medicaid population or to informing them of available services.
- 5) All FQHC costs are reported on the cost report, including unallowable costs and costs for certain services and supplies billed outside of the encounter rate.
 - a. Unallowable costs must be reported on Worksheet 1, Section B of the cost report, with some costs then being adjusted out of the cost report, as appropriate.
 - b. The costs for services and supplies billed outside of the encounter rate must be reported on Worksheet 1, Section B of the cost report. A list of services and supplies for which the FQHC may bill outside of the encounter rate is included in the *Worksheet 1* section of these instructions.
- 6) Revenue received through a Medicaid grant for Medicaid client services must be offset against expense on the cost report to prevent duplicative Medicaid payments for services rendered.
- 7) The cost associated with providing group sessions may be included in the cost report, even though the associated visits cannot be billed as an encounter.
- 8) A portion of employee time and/or physical space dedicated to an unallowable cost must be reclassified to a non-reimbursable cost center if there is a measurable amount of time and/or space.

Cost Report Filing Requirements

This manual contains the instructions for completing the Medicaid cost report for FQHC facilities in the State of Colorado. All FQHCs participating in the Medicaid program must file a cost report annually in order to maintain compliance with the program.

FQHCs must submit a Pharmacy Overhead Allocation Form along with their cost report forms. The Pharmacy Overhead Allocation Form may be found [here](#).

Newly designated FQHCs shall file a preliminary cost report with estimated data. The data from the preliminary cost report shall be used to set a reimbursement base rate for the first year. The Department will determine a newly designated FQHC's PPS rate based on the first full year of actual cost and visit data from the FQHC cost report.

The cost report must be filed with the Department's contractor no later than 90 days after the end of the FQHC's fiscal year. An extension of up to 75 days may be granted based upon individual circumstances; however, the FQHC must contact the Department's contractor prior to the due date to request an extension. A properly filed extension request will not delay the encounter rate effective date. Failure to submit a cost report within 180 days after the end of the fiscal year shall result in suspension of payments.

Cost Report Forms

Current Medicaid cost report forms will be distributed to FQHCs in January of each year. (See *Appendix A* for a complete set of forms.) The line numbers and cost center descriptions on the preprinted form should be used as formatted and not changed. Blank lines are provided for additional cost centers that may be needed; these should be labeled clearly if used.

All of the cost report forms must be completed. Each form should be accurate, completed according to instructions, and in as much detail as possible. The prescribed forms must be used by each FQHC. No substitute forms will be accepted. Indicate N/A on forms that do not apply to the FQHC or are not needed. Do not exclude these forms from the cost report submission.

Many cells in the forms contain formulas established for correct calculations. These formulas should not be changed. A description of each formula is provided so the resulting figures can be verified by the cost report preparer.

The following rounding standards should be used for fractional computations:

- a. Round to 2 decimal places
 - Rates
 - Cost per visit
- b. Round to 6 decimal places
 - Ratios
 - Limit adjustments

All other numbers (worksheet columns) should be reported as whole numbers; cents should not be included in dollar figures.

Each FQHC must file a complete cost report package in order to maintain Medicaid program compliance. The complete cost report package includes the following forms:

- Statistical Data/Certification Form
- Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses
- Worksheet 1 – Supplement 1 – Reclassifications
- Worksheet 1 – Supplement 2 – Adjustments to Expenses
- Worksheet 2 – Allocation of Expenses
- Worksheet 3 – Provider Staff, Visits and Productivity
- Worksheet 4 – Determination of Encounter Rates
- Addendum 1 – Encounter Report
- Addendum 2 – Unallowable Expenses
- Addendum 3 – Administration Breakdown

The following documents must be submitted with the FQHC cost report package:

- Audited financial statements
- Working trial balance with crosswalk (see example in *Appendix B*)
- Detailed breakdown of all expenses reported as “other” or “miscellaneous”
- Full Time Equivalents (FTE) report by department for all staff of the FQHC (see example in *Appendix B*)
- Completed Pharmacy Overhead Allocation Form (see form in *Appendix C*; the Excel version of the Pharmacy Overhead Allocation Form may be found [here](#).)

Submission of the Cost Report

The cost report must be filed in electronic (Excel) format, whether sent via email or burned onto a CD and sent via mail. A scanned copy of the signed Statistical Data/Certification form may be emailed or burned onto a CD and mailed, or a paper copy may be sent.

Submissions can be emailed to infosubmit@mslc.com.

Submissions can be mailed to:

Myers and Stauffer LC
 Attn: FQHC Cost Reports
 6312 S. Fiddlers Green Circle, Suite 510N
 Greenwood Village, CO 80111
 Phone: 303-694-3605

Maintenance of Records

All accounting, financial, medical and other records relevant to the cost report package or supporting documentation must be maintained for a minimum of six years following the date of the filing of the cost report.

Informal Reconsideration and Appeal

An FQHC has thirty (30) days from the mailing date of the rate notification letter to file a written appeal or informal reconsideration, pursuant to 10 C.C.R 2505-10, Section 8.050.3.A. Appeals should be addressed to:

Jennifer Weaver
First Assistant Attorney General
Department of Law, Health Care Unit
Ralph L. Carr Colorado Judicial Center
1300 Broadway, 6th Floor
Denver, CO 80203

Erin Johnson
FQHC Rates Analyst
Fee-for-Service Rates Section
Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

STATISTICAL DATA/CERTIFICATION FORM

The Statistical Data/Certification form collects statistical and informational data on the FQHC.

Section 1 – Cost Report Submission and FQHC Data

Report the date the cost report is submitted to the Department’s contractor. Report the full legal name and address of the FQHC. Include the phone number, fax numbers and email address for the cost report contact. The “Date Received” should be left blank and will be completed by the Department’s contractor upon receipt.

Section 2 – FQHC National Provider Identifier Numbers

In the first column, report the assigned National Provider Identifier (NPI) number for each site operated by the FQHC. In the second column, report the Medicaid ID that corresponds to the NPI number in the first column. If there are more facility sites than lines, this data may be reported on a separate schedule (Stat Data Tab 2) of the Statistical Data/Certification Form. FQHCs should prepare and submit one cost report for all sites combined.

Section 3 – Reporting Period

Report the beginning date and end date of the reporting period. This should coincide with the FQHC’s fiscal year.

Section 4 – Type of Control

Select the type of control using the drop-down menu in the appropriate area.

Section 5 – Other Federally Qualified Health Centers, Providers of Service including Rural Health Clinics, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Suppliers or Other Entities that are owned or related through Common Ownership or Control to the Individual or Entity

Report all entities that are owned by, or related through common ownership or control to, the FQHC (i.e. other FQHCs, rural health clinics, hospitals, skilled nursing facilities, home health agencies, suppliers, etc.).

Section 6 – Source of Federal Funds

Report the type of Federal funding awarded to the reporting FQHC by placing an X next to each source of funding.

Certification by Officer or Administrator of Clinic

Insert cost report preparer information. Note all deviations from State rules/instructions, if applicable. The cost report must be signed by an officer or administrator of the FQHC authorized by the Board of Directors with signatory authority. If the cost report is filed electronically via email, a scanned copy of the signed Statistical Data/Certification form must be emailed or faxed.

WORKSHEET 1

Reclassification and Adjustment of Trial Balance of Expenses

This form is used to report total costs of the FQHC for the reporting period. Cost centers that do not apply to the FQHC may be left blank. “Other (Specify)” lines are provided for additional cost centers needed; these must be clearly labeled if used. If additional space is needed, enter the total of several cost center expenses on a blank line and provide the detail as an attachment.

Reliable documentation must be maintained to support cost splits between covered health care costs, non-reimbursable costs and overhead costs. Unallowable and non-reimbursable costs must be properly classified or removed as appropriate. Costs for services delivered by State-approved providers are included as covered health care costs on the cost report and the related visits cannot be billed in any manner other than via the annually established encounter rate. Costs associated with Medicaid-covered services that are not delivered by a provider listed as an Eligible Provider in State regulations (e.g. physical therapy) shall be included on the cost report, but associated visits should not be reflected on Worksheet 3 (as they do not generate a separately billable encounter).

Costs for contracted services provided by Community Mental Health Center (CMHC) staff are included in the cost report. Separate visits for services provided by CMHC staff should be included in the cost report when the encounter complies with the definition of distinct behavioral health visit.

Costs for services not reimbursed via the encounter rate are “carved out” of the cost report. These costs are either reimbursed to the FQHC on a fee-for-service basis or via a separate billing number (e.g. pharmacy), depending on the type of cost. These costs are reported on Worksheet 1, Section B of the cost report. The “carved out” services are:

- ∗ Services provided to patients on an inpatient basis in a hospital
- ∗ Pharmacy
- ∗ Long Acting Reversible Contraception (LARC) devices
- ∗ Dentures and partial dentures
- ∗ Services provided under the Prenatal Plus Program
- ∗ Services provided under the Nurse Home Visitor Program
- ∗ Dental services provided to patient on an outpatient basis in a hospital

Costs for services that are not covered are reported as non-reimbursable costs on Worksheet 1, Section B of the cost report. Examples of services that are not covered include the following:

- ∗ Chiropractic services
- ∗ Alternative medicine such as acupuncture
- ∗ Investigative and experimental treatments
- ∗ Lamaze, birthing and parenting classes
- ∗ Infertility treatments
- ∗ Spermicide, female condoms, home pregnancy tests

- Sterilization reversal
- Ultrasounds performed only for determination of the sex of the fetus or to provide a keepsake photo
- Three- and four-dimensional ultrasounds
- Paternity testing
- Home tocolytic infusion therapy
- Clinical pharmacist costs

Note: Clinical pharmacists provide comprehensive medication services for patients at clinical locations in collaboration with primary care providers.

Diabetes self-management education programs are a Medicaid-covered service for an FQHC as of July 1, 2015. The program at the FQHC must be recognized by the American Diabetes Association (ADA) or the American Association of Diabetes Educators (AADE) as a Diabetes Self-Management Education program in order to be reimbursable. If recognized as such, the FQHC may include the costs of the diabetes self-management education program on the cost report, and may generate an encounter when there is a one-on-one, face-to-face visit with an Eligible Provider (physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor). The program costs may be included on the cost report, and used in the subsequent calculations that determine the FQHC's per-visit encounter rate, even if the visit does not generate an encounter. The program costs are not considered covered services if the program is not recognized by the ADA or AADE.

Columns of Worksheet 1

Columns 1 through 5

These columns identify costs in accordance with the accounting records. The FQHC must present a crosswalk from the accounting system-generated trial balance to the lines on Worksheet 1. See *Appendix B* for an example.

Column 1 – Compensation

Cost of salaries and wages paid to FQHC employees.

Column 2 – Fringe Benefits

Cost of fringe benefits paid on behalf of FQHC employees. It is acceptable for fringe benefits to be pro-rated to cost centers based upon salary figures. Fringe benefits includes FICA, Medicare, health insurance, disability insurance, profit sharing, unemployment, worker's compensation, continuing medical education if specific to medical providers, dues and subscriptions if part of the provider contract, other benefits, etc.

Column 3 – Purchased & Contract Services

Cost of contracted services paid other than to employees (i.e. locum tenens providers, laboratory, radiology, janitorial, etc.).

Column 4 – Other

Miscellaneous costs that do not fit into the other columns such as supplies, transportation, etc.

Column 5 – Total

Total of Columns 1 through 4. The total cost in Column 5 must agree to the audited financial statements for the fiscal year being reported as well as the trial balance generated from the accounting system.

Column 6 – Reclassifications

This column is provided to record reclassifications of expense that are necessary for proper cost allocation. The cost centers affected should be identifiable and documented in the FQHC's records and/or the cost report work papers. Reclassifications are necessary when the expenses applicable to more than one of the cost centers listed on Worksheet 1 are maintained in the FQHC's accounting books and records in one cost center or account. For example, if a physician performs administrative duties, the appropriate portion of his or her compensation, fringe benefits and payroll taxes should be reclassified from Covered Health Care Costs to Overhead Costs. The total of all entries in Column 6 on Line D – Total Costs must equal zero.

Worksheet 1 – Supplement 1 (Reclassifications) is provided to identify the reclassifications necessary for proper cost allocation. Detailed instructions regarding reclassifications of expense can be found in the *Worksheet 1 – Supplement 1* section of these instructions.

Column 7 – Reclassified Trial Balance

This column reflects the sum of the entries in Column 5 adjusted (increased or decreased) by the reclassification amounts in Column 6. Column 7, Line D – Total Costs must agree to Column 5, Line D – Total Costs.

Column 8 – Adjustments Increase or (Decrease)

This column is provided to record non-reclassification adjustments to expense. Adjustments include the removal of unallowable costs and costs for non-FQHC approved services that are not required to receive an allocation of the FQHC's overhead expenses.

Worksheet 1 – Supplement 2 (Adjustments to Expenses) is provided to record adjustments necessary for proper cost allocation. The total of Column 8 should equal the total of the adjustments recorded on Worksheet 1 – Supplement 2. Further instructions regarding adjustments of expense can be found in the *Worksheet 1 – Supplement 2* section of these instructions.

Column 9 – Net Expense

This column reflects the sum of the entries in Column 7 adjusted (increased or decreased) by the amounts in Column 8. These are the final reported costs for the encounter rate calculation.

Lines of Worksheet 1

Section A: Covered Health Care Costs

These are costs incurred to provide a finished health care product or service including, but not limited to, salaries and benefits of direct health care staff, contractual payments for direct health care, supplies and materials, purchase of medical and dental equipment under the FQHC capitalization threshold, and repair and maintenance of medical and dental equipment.

Subsection 1: Physical Health Costs

Line 1 – Physicians

Costs incurred for physicians who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

If the contract, job description or employment agreement for physicians or other health care staff includes the requirement and guarantee of payment towards continuing education, these costs should be included in Column 2 for the appropriate health care staff.

If the FQHC pays hospital dues or similar costs directly to institutions where health care providers provide care to FQHC clients, these costs should also be included in Column 2 for the appropriate health care staff.

Line 2 – Physicians Assistants

Costs incurred for physician assistants who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 3 – Nurse Practitioners

Costs incurred for nurse practitioners who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 4 – Nurse-Midwife

Costs incurred for nurse-midwives who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 5 – Podiatrists

Costs incurred for podiatrists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 6 – Other Nurses (RN/LPN)

Costs incurred for registered nurses or licensed practical nurses who are furnishing direct health care services to patients. This line is for reporting licensed nurses.

Line 7 – Medical Assistants/Nurse Aides

Costs incurred for medical assistants or nurse aides who are furnishing direct health care services to patients. Report unlicensed nurses on this line.

Line 8 – Medical Interns/Residents

Costs incurred for interns and residents who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Lines 9-13 – Other Behavioral Health Services

Costs reported in this section should reflect the cost for behavioral health services not reimbursable

through either the RAEs or the 6 Short Term Behavioral Health (STBH) visits. The cost of behavioral health professional providing integrated or joint visits that do not generate a separate behavioral health visit should be included. Cost associated with behavioral health services provided to patients which are included in the behavioral health capitation as RAE covered services and six (6) Short Term Behavioral Health (STBH) services are reported in the specialty behavioral health section Subsection 3 Specialty Behavioral Health Care Costs Lines 35 - 40, regardless of payer.

Line 9 – Psychiatrists – Non-RAE/STBH Services

Costs incurred for psychiatrists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Behavioral Health Specialty Rate section.

Line 10 – Licensed Clinical Psychologists – Non-RAE/STBH Services

Costs incurred for licensed clinical psychologists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Behavioral Health Specialty Rate section.

Line 11 – Licensed Clinical Social Workers – Non-RAE/STBH Services

Costs incurred for licensed clinical social workers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Behavioral Health Specialty Rate section.

Line 12 – Other Licensed Behavioral Health Providers – Non-RAE/STBH Services

Costs incurred for licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, other licensed behavioral health providers who are furnishing direct healthcare services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Behavioral Health Specialty Rate section. This includes psychiatric social workers, psychiatric nurse practitioners, family therapists, licensed marriage and family therapists, licensed professional counselors and licensed addiction counselors and other licensed Master's Degree-prepared clinicians.

Line 13 – Other Behavioral Health Providers – Non-RAE/STBH Services

Costs incurred for other behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Behavioral Health Specialty Rate section.

Line 14 – Laboratory – Medical

Costs incurred for in-house laboratory services including staff salary, fringe benefits and supplies. Do not include off-site laboratory costs on this line as they are to be reported in the Non-Reimbursable section of the cost report. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with that service may remain in the cost report.

Line 15 – X-Ray – Medical

Costs incurred for in-house radiology services including staff salary, fringe benefits and supplies. Do not include off-site radiology costs on this line as they are to be reported in the Non-Reimbursable section of the cost report. If the FQHC can demonstrate through contract with the off-site radiology contractor that only the FQHC is billed for services rendered, and not third-party payers, the costs

associated with that service may remain in the cost report.

Line 16 – Physical Therapy

Costs incurred from services provided by a physical therapist. Physical therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter. Visits for physical therapy services delivered by an approved provider (e.g. physician, physician assistant, or nurse practitioner) may be billed via the encounter rate.

Line 17 – Occupational Therapy

Costs incurred from services provided by an occupational therapist. Occupational therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 18 – Vocational Therapy

Costs incurred from services provided by a vocational therapist. Vocational therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 19 – Speech Pathology

Costs incurred from services provided by a speech pathologist. Speech pathologists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 20 – Health Education

Costs incurred for delivery of health education information or materials directly to patients. Included are healthy diet programs and nutritional counseling if performed by a registered dietician, smoking cessation programs, etc.

Line 21 – Medical Supplies

Costs incurred for the purchase and utilization of medical supplies in the FQHC clinics.

Line 22 – Optometry Supplies

Costs incurred for the purchase and utilization of optometry supplies in the FQHC clinics.

Line 23 – Pharmaceuticals Incident to a Service

Costs for pharmaceuticals that are used incident to a provided service (aspirin, vaccines, etc.).

Line 24 – Medical Small Equipment

Costs for the purchase of equipment utilized to deliver clinical services to patients under the Federal capitalization threshold of \$5,000.

Line 25 – Medical Equipment Repairs & Maintenance

Costs for minor repairs and maintenance to equipment utilized to deliver clinical services to patients.

Line 26 – Malpractice – Physician

Costs incurred for the portion of malpractice insurance relative to the providers and not to administrative staff. The providers of most FQHCs are covered for malpractice through the Federal Tort Claims Act (FTCA) and there is no cost to the FQHC; however, some FQHCs carry gap policies.

Line 27 – Other Physical Health

Line 27 is to be used to report any other physical health covered health care costs that do not fit on Lines 1 through 26. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 2: Dental Costs

Line 28 – Dentists

Costs incurred for dentists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 29 – Dental Hygienists

Costs incurred for dental hygienists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 30 – Dental Assistants

Costs incurred for dental assistants who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 31 – Dental Laboratory and Supplies

Costs incurred for the in-house dental laboratory services, excluding dentures and partial dentures, and costs incurred for the purchase and utilization of dental supplies in the FQHC clinics.

Line 32 – Dental Small Equipment

Costs for the purchase of equipment utilized to deliver clinical services to patients under the Federal capitalization threshold of \$5,000.

Line 33 – Dental Equipment Repairs & Maintenance

Costs for minor repairs and maintenance to equipment utilized to deliver clinical services to patients.

Line 34 – Other Dental Health

Line 34 is to be used to report any other Dental Health covered health care costs that do not fit on Lines 28 through 33. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 3: Specialty Behavioral Health Care Costs

Costs reported in this section should reflect the cost for services included in the Colorado Behavioral Health Capitation as RAE covered services and Short Term Behavioral Health services in the primary care setting benefit. Effective July 1, 2018, costs incurred for behavioral health workers (licensed professional counselors and registered psychotherapists) who are furnishing direct health care services to patients that are for a RAE-covered behavioral health service are reported in this section.

Line 35 – Psychiatrists

Costs incurred for psychiatrists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 36 – Licensed Clinical Psychologists

Costs incurred for licensed clinical psychologists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 37 – Licensed Clinical Social Workers

Costs incurred for licensed clinical social workers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 38 – Other Licensed Behavioral Health Providers

Costs incurred for other licensed behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors. This includes licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Master’s Degree-prepared clinicians.

Line 39 – Other Behavioral Health Providers

Costs incurred for other behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors. This includes unlicensed individuals and “certified” individuals who provide counseling, or support to behavioral health providers, as well as interns, residents, or candidates for licensure in any of the other professions identified in lines 37 through 39.

Line 40 – Other Specialty Behavioral Health

Any other behavioral health capitation and limited direct access therapy benefit covered health care costs that do not fit on Lines 35 through 39 are reported in this line. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 4: Costs to be Allocated across All Rates

Some covered health care costs are not directly applicable to one specific rate. These costs are included in this section and will be allocated appropriately across all three separate rates unless the FQHC can directly allocate costs to a specific service. Costs which can be directly allocated may be reclassified in column 6. Remaining costs will be allocated across all three rates on Worksheet 2.

Line 41 – Medical Records

Costs incurred for time spent by clinic staff directly on patient medical records. Costs for staff that perform medical records tasks in addition to other clerical tasks must be split between covered health care costs and overhead. Costs associated other clerical tasks (not medical records) are reported in Part C: Overhead Costs of Worksheet 1.

Line 42 – Translation

Costs incurred for translation services that are incurred for direct patient care (e.g. during a visit) and are reasonable in amount. The cost of multilingual call center/reception staff or administration staff are reported on Worksheet 1, Section C, Overhead Costs.

Line 43 – Patient Transportation

Costs incurred for transporting patients, as well as staff travel costs that are incurred for direct patient care and are reasonable in amount.

Line 44 – Case Management

Costs incurred for the delivery of case management services directly to patients.

Line 45 – Outstationing

Costs associated with outstationing activities provided to patients, such as salary, fringe benefits, travel, training, maintenance of equipment, etc. The costs in this line are not limited to Medicaid-only outstationing costs.

Each FQHC that participates in the State Medicaid program must have a person qualified to take Medicaid applications and assist applicants with the application process. When an FQHC has more than one site, applications for Medicaid must be taken at all sites during the normally scheduled site hours of operation. Initial processing means taking applications, assisting applicants in completing the application, providing information and referral, obtaining required documentation needed to complete processing of the application, assuring completeness of the information contained on the application, and conducting interviews. Initial processing does not mean evaluating the information contained on the application and the supporting documentation or making a determination of eligibility or ineligibility (CMS State Organization and General Administration Manual, sections 2905-2913).

Line 46 – Other Covered Health Care Costs

This line is used to report any other direct health care costs which require allocation across all rates.

Line 47 – Total Covered Health Care Costs

Total of all costs on Lines 1 through 46.

Section B: Non-Reimbursable Costs

These costs are incurred to provide:

1. Medicaid-covered services that are reimbursed outside of the FQHC cost report; and
2. Services that are not reimbursed under Colorado’s Medicaid State Plan Amendment, are not in the FQHC’s scope of project, or do not meet the Medicare definition of FQHC services.

Subsection 1: Services Reimbursed Outside of the Cost Report

Line 48 – Pharmacy

An FQHC that operates its own pharmacy that serves Medicaid patients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number. In this case, because pharmacy costs are paid to the FQHC via a dispensing fee, all direct costs related to the pharmacy must be reported in Worksheet 1, Section B. Direct costs related to a pharmacy that does not serve Medicaid patients should also be reported in this section.

According to the Colorado Medicaid Provider Bulletin dated October 2014, providers that participate in the federal 340B Drug Pricing Program must document and ensure compliance with all 340B Drug

Pricing Program requirements. If providers choose to purchase and dispense 340B drugs to their Medicaid members, they must inform the Health Resources and Services Administration (HRSA) at the time of enrollment in the 340B Program by providing their Medicaid provider and National Provider Identifier (NPI) numbers. This information will be reflected on the HRSA Medicaid Exclusion File so that states and manufacturers can verify that drugs purchased under a Medicaid provider number are also eligible for a Medicaid rebate. If providers decide to bill Medicaid for drugs purchased under 340B, then all drugs billed under that Medicaid provider number/NPI must be purchased under 340B. For providers that opt to purchase Medicaid drugs outside of the 340B Program, all drugs billed under that Medicaid provider number/NPI must be purchased outside the 340B Program; the Medicaid provider number/NPI should not be listed on the HRSA Medicaid Exclusion File.

Some FQHCs establish 340B program contracts with outside companies to make prescription drugs available to FQHC patients at retail pharmacies. These contracts must be written to exclude Medicaid patients from the 340B program because the State of Colorado is eligible for rebates on pharmaceuticals provided to Medicaid patients. It is illegal for the State to get a rebate for a pharmaceutical provided to a Medicaid patient and for the prescription to be filled with discounted 340B drugs. HRSA, as well as the Centers for Medicaid and Medicare Services (CMS), place the burden of properly managing these 340B programs on the FQHC.

Because 340B program contracts are not applicable to Medicaid patients, the costs of these programs, up to the amount of revenue generated, must be reported on Line 49 of the cost report and receive an allocation of the FQHC's overhead expense. Costs of this type of 340B program include the cost of the drugs purchased, fees incurred and paid to the contracted company to administer the program, and any other costs specifically incurred for the contracted program.

Pharmacy costs must receive an allocation of the FQHC's overhead expenses. Pharmacy overhead costs are allocated through the Pharmacy Overhead Allocation Form, unless the FQHC allocates overhead costs directly to the Pharmacy at the invoice level. Use of the direct allocation method should be noted and attested to on the Pharmacy Overhead Allocation Form.

Example: An FQHC has a contract with Capture Rx and the following figures are available:

- Revenue generated = \$200,000
- Cost of drugs = \$70,000
- Fees paid to Capture Rx = \$80,000
- Revenue in excess of expense = \$50,000
- The FQHC must report the cost of drugs and the fees paid to Capture Rx (\$70,000 and \$80,000, respectively) on Line 48 the cost report

Line 49 – LARC Devices

Costs incurred for LARC devices. Costs incurred for the insertion or removal of LARC devices should be included in Section A: Covered Health Care Costs. This line should total \$0 in column 9.

Line 50 – Inpatient Hospital

Costs incurred by the FQHC to provide services in an inpatient hospital setting and on-call costs related to inpatient services. If applicable, on-call inpatient hospital costs may be identified using an

appropriate cost allocation methodology. This line should total \$0 in column 9.

Line 51 – Dentures and Partial Dentures

Costs incurred by the FQHC to provide dentures and partial dentures to patients. This includes costs for staff time, contracted work, lab work, supplies, etc. These costs must receive an allocation of overhead expenses.

Line 52 – Dental Services Provided in an Outpatient Hospital Setting

Costs incurred by the FQHC to provide dental services in an outpatient hospital setting. This line should total \$0 in column 9.

Line 53 – Prenatal Plus Program

Costs incurred through a separate contract with the State of Colorado for the Prenatal Plus Program. The Prenatal Plus Program is a special program for pregnant women on Health First Colorado (Colorado’s Medicaid Program) who qualify. Prenatal Plus involves a team of providers working together to help reduce the chances of low birth weight. This line should total \$0 in column 9.

Line 54 – Nurse Home Visitor Program

Costs incurred through a separate contract with the State of Colorado for the Nurse Home Visitor Program (NHVP). NHVP is a program for qualifying women who are pregnant with their first child. The program is also for these first children up to their second birthday. NHVP offers case management and health education services to moms and their first babies in order to help them get the medical and social services they need. This line should total \$0 in column 9.

Line 55 – Offsite Laboratory/X-Ray/Specialty Care Office Visits

Costs paid by the FQHC for laboratory, radiology, specialty care, etc. are non-reimbursable as these visits are typically billed to Medicaid by the provider of the service. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with that service should be included in Section A: Covered Health Care Costs. This line should total \$0 in column 9.

Line 56 – Other (Specify)

This line is used to report costs for any other services reimbursed outside of the cost report. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 2: Non-Reimbursable Services

Line 57 – Services Not Covered by Colorado Medicaid

Costs incurred by the FQHC to provide services not covered by Colorado Medicaid. Examples of these services can be found in the *Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses* section of this document.

Line 58 – Marketing

Costs of unallowable advertising and staff that perform marketing functions. These costs must receive an allocation of overhead expenses. Allowable advertising and public relations costs are reported in Section C: Overhead Costs. All advertising, marketing, development, public relations, and related costs not defined as allowable in Section C: Overhead Costs must reported on Line 58 of the cost

report. These include, but are not limited to:

- Costs of promotional items and memorabilia, including models, gifts, and souvenirs.
- Costs of advertising and public relations designed solely to promote the provider.
- Costs of general advertising and public relations designed solely to increase patient utilization.

Line 59 – Unallowable Outreach

Costs incurred to perform outreach services into the general community. These costs must receive an allocation of overhead expenses.

Line 60 – Fundraising

Costs of fundraising and staff that perform fundraising functions. These costs must receive an allocation of the FQHC’s overhead expenses.

Line 61 – Grant Writing

Costs of grant writing and staff that perform grant writing functions. These costs must receive an allocation of overhead expenses.

Line 62 – Other (Specify)

This line is used to report costs for any other services that are non-reimbursable. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Line 63 – Total Non-Reimbursable Costs

Total of all costs on Lines 48 through 62.

Section C: Overhead Costs

All remaining costs should be reported in Section C: Overhead Costs. Overhead costs will be allocated across covered and non-reimbursable costs on worksheet 3. Non-reimbursable pharmacy overhead costs will be allocated using the Pharmacy Overhead Allocation Form.

Line 64 – Administration

Costs incurred for administrative staff such as the chief executive officer, the executive director, administrative assistants, secretaries, business managers, clinic managers, front desk supervisors, office technicians, special projects staff, medical office managers, and any other staff that do not participate in the direct delivery of health care products and services but are necessary for operation of the FQHC.

Administrative time of provider staff (chief medical officer, medical director, and assistant medical director) should be included on Line 64 and will most likely be reclassified from Section A: Covered Health Care Costs.

Other costs reportable on Line 64 include the following:

- Board of Directors – stipends, mileage, meetings, retreats
- Contract services for administrative projects – interim administrative staff, etc.
- Dues & subscriptions for the company – not specific to a provider contract

- Recruitment costs – administrative staff; costs incurred for recruitment of staff reported in *Section A – Covered Health Care Costs* can be reported in that section.
- Printing – brochures, patient handbooks, forms, etc.
- License fees for the company or administrative staff

Interest costs, with the exception of mortgage interest, are reported on Line 64. This would include interest incurred on lines of credit, financing of equipment, etc.

Do not include overhead costs in Line 64 that have a separate cost center available on Worksheet 1. For example, information technology and depreciation have specific cost centers in the overhead section of Worksheet 1. These costs should be reported in their respective cost centers, and should not be included on Line 64.

Line 65 – Call Center/Reception

Costs incurred for call center/reception staff.

Line 66 – Quality & Compliance

Costs incurred for quality and compliance staff and projects.

Line 67 – Finance

Costs incurred for financial staff, such as the chief financial officer, finance director, controller, assistant controller, accountants, accounting technicians, accounts payable clerks, payroll clerks, etc. Other costs reportable on Line 66 include the following:

- Audit fees
- Financial statement preparation costs
- Costs of financial consultants

Line 68 – Information Technology (IT)

Costs incurred for information technology staff including the director, assistant director, coordinator, programmers, technicians, computer operators, etc.. Also include other IT costs such as software and hardware upgrades and maintenance agreements.

Line 69 – Billing and Coding

Costs incurred for billing and coding staff.

Line 70 – Legal

Costs incurred for legal services. This includes all legal costs including attorney fees, court costs, out-of-court settlements, etc.

Line 71 – Housekeeping

Costs incurred for janitorial staff or contracted labor, as well as janitorial supplies.

Line 72 – Maintenance/Repair

Costs incurred for maintenance or repair of administrative facilities and equipment, as well as the cost of waste disposal.

Line 73 – Security

Costs incurred for security staff, non-depreciable security systems (cost of \$5,000 or less) and security monitoring fees.

Line 74 – Supplies

Costs incurred for administrative supplies used in clinics, office supplies, postage, books, accounting supplies, medical records supplies, etc. Additionally, non-clinical and office equipment purchased at a cost under the Federal capitalization threshold of \$5,000 is reported here.

Line 75 – Insurance

Costs incurred for insurance including the following:

- ✓ Building coverage
- ✓ Equipment coverage
- ✓ Vehicle coverage
- ✓ Liability coverage
- ✓ Errors & omissions coverage
- ✓ Employee theft or embezzlement

The cost of provider malpractice insurance is reported on line 26 in Section A: Covered Health Care Costs.

Line 76 – Malpractice – Clinic

Costs incurred for the purchase of malpractice insurance for non-providers and other costs such as deductibles and co-payments. The cost of provider malpractice insurance is reported on line 26 in Section A: Covered Health Care Costs.

Line 77 – Allowable Advertising, Outreach and Public Relations

Costs incurred for allowable advertising, outreach and public relations. The only advertising costs allowable on the cost report are:

- ✓ Costs for placing informational advertisements containing FQHC location, services, hours, and contact information targeted at the FQHC’s target population.
- ✓ Costs associated with the recruitment of personnel that would be involved in patient care activities or the development and maintenance of the facility (including medical, paramedical, administrative, and clerical personnel).
- ✓ Advertising costs for procuring items or services related to patient care.
- ✓ Advertising costs for the sale or disposition of surplus or scrap material.
- ✓ Advertising costs for obtaining bids for construction or renovation of the provider’s facilities.
- ✓ Advertising costs that are incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care.

The only public relations costs allowable on the cost report are:

- Costs of communicating with the public and press pertaining to specific activities or accomplishments that result from the performance of the federal award.
- Costs of conducting general liaison with news media and government public relations officers only to the extent that such activities are limited to communication and liaison necessary keep the public informed on matters of public concern.

Line 78 – Telephone

Costs incurred for telephone expense (land lines, cell phones, pagers, answering service) as well as for phone system leases.

Line 79 – Utilities

Costs incurred for utilities for the FQHC facilities including heat, electricity, etc.

Line 80 – Rent

Costs incurred for rental of facilities, equipment, vehicles, and any other type of rental or lease costs. Expense recorded for donated rent must be adjusted out in Column 8.

Line 81 – Depreciation

Expense recorded for depreciation of the capitalized cost of medical equipment, non-medical equipment, furniture, office equipment, computer equipment, buildings, vehicles, etc. The FQHC must be the recorded title holder of the equipment and the assets must be identifiable and recorded in the accounting records in accordance with Generally Accepted Accounting Principles.

Single items of equipment valued at a cost of \$5,000 or more with an estimated life of over one year are to be depreciated. Depreciation must be prorated over the estimated useful life of the asset using the straight-line method. The estimated useful life of a depreciable asset is its normal operating or service life to the FQHC. Leasehold improvements may be depreciated over the shorter of the asset's useful life or the remaining life of the lease. The fixed asset records shall include for each asset: a description, the date acquired, estimated useful life, depreciation method, historical cost or fair market value, salvage value, depreciable cost, depreciation for the current reporting period, and accumulated depreciation.

Line 82 – Amortization

Expense recorded for amortization of the capitalized cost of items such as bond costs, loan costs, etc.

Line 83 – Contributions

Costs incurred for contributions to other entities including both those directly related to the provision of health care and those that are not directly related to the provision of health care.

Line 84 – Travel and Transportation

Costs incurred by non-health care staff for non-patient transportation, messenger service, mileage, medical records transportation, lodging and meals (when applicable), etc. Health care staff travel and transportation costs are reported in Section A: Covered Health Care Costs.

Line 85 – Mortgage Interest

Costs incurred for real estate mortgage interest. This line is only for interest paid on facility debt. All other interest (lines of credit, equipment loans, etc.) is to be reported on Line 64 – Administration. Interest income will be adjusted out in Column 8 up to the amount of interest expense.

Line 86 – Property Tax

Costs incurred for property tax on property used in the FQHC operation.

Line 87 – Human Resources

Costs incurred for human resources employees responsible for recruiting, screening, interviewing, and placing workers in addition to managing employee relations, benefits, and training.

Line 88 – Other Overhead

This line is used to report any other overhead costs that do not fit on Lines 64 through 87. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Line 89 – Total Overhead Costs

Total of all costs on Lines 64 through 88.

Section D: Total Costs

Total of Sections A, B and C (Lines 47, 63, and 89)

WORKSHEET 1 – SUPPLEMENT 1

Reclassifications

This form identifies and explains cost reclassifications that are reflected in Column 6 of Worksheet 1. Reclassifications are necessary in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet 1 are maintained in the facility's accounting books and records in one cost center or account. This form enables those expenses to be reclassified to the proper cost report line.

All reclassifications are entered on this form. After the reclassifications have been entered, the total of Columns 4 and 7 (which should agree to each other) are entered on Line 36. The reclassification entries are then transferred to the appropriate lines on Worksheet 1, Column 6.

Examples of costs that require reclassification are as follows:

1. Administrative and Health Care Services Duties

It is common for a provider to perform administrative duties as a chief medical officer, medical director, or assistant medical director, and also spend time delivering health care services directly to patients. Often 100% of the salary and fringe costs for these providers are reported in the Covered Health Care Costs section of Worksheet 1. The appropriate portion of the provider salary and fringe benefits relative to the administrative duties should be reclassified from the Covered Health Care Costs section to the Overhead Costs section. No reclassification is necessary if the FQHC records the administrative portion of the salary and fringe in a separate account in the accounting system.

2. Services Provided in the FQHC and Hospital

FQHC providers will oftentimes deliver health care services to clients in an inpatient hospital setting, particularly in rural areas. These services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate. Similar to the first example, it is common for 100% of the salary and fringe costs for these providers to be reported in the Covered Health Care Costs section of Worksheet 1. Therefore, the portion of salary and fringe benefits relative to inpatient health care services should be reclassified from the Covered Health Care Costs section to the Non-Reimbursable Costs section. No reclassification is necessary if none of the providers deliver health care services in the hospital setting.

Columns of Worksheet 1 – Supplement 1

Explanation of Entry

This column provides an explanation for the reclassification, such as “physician administrative time” or “physician inpatient time.”

Column 1 – Code

This column is used to identify an alphabetical code for each reclassification entry. The first is A, and then B, and so on.

Column 2 – Cost Center

This column identifies the cost center (line) from Worksheet 1 that will be increased by the reclassification.

Column 3 – Line Number

This column identifies the line number relative to the cost center in Column 2 that will be increased by the reclassification.

Column 4 – Amount

This column identifies the amount by which the cost center in Column 2 will be increased.

Column 5 – Cost Center

This column identifies the cost center (line) from Worksheet 1 that will be decreased by the reclassification.

Column 6 – Line Number

This column identifies the line number relative to the cost center in Column 5 that will be decreased by the reclassification.

Column 7 – Amount

This column identifies the amount by which the cost center in Column 5 will be decreased.

WORKSHEET 1 – SUPPLEMENT 2

Adjustments to Expenses

This form identifies and explains adjustments to the expenses listed on Worksheet 1. Many of these adjustments follow the Medicare rules and regulations. Pre-printed line descriptions indicate the more common activities that result in adjustments to expenses. There are also a number of blank lines to record adjustments not specifically identified on the form and specific to individual FQHCs.

All non-reclassification adjustments are entered on this form, including:

- ✓ Unallowable costs identified on Addendum 2
- ✓ Other adjustments to allowable costs as defined in these instructions

After the adjustments have been entered, they are transferred to the appropriate lines on Worksheet 1, Section D, Column 8.

Columns of Worksheet 1 – Supplement 2

Explanation of Entry

This column provides an explanatory description of the type of cost adjustment.

Column 1 – Cost Center

This column identifies the cost center on Worksheet 1 that is being adjusted.

Column 2 – Line Number

This column identifies the line number on Worksheet 1 that is being adjusted.

Column 3 – Amount

This column identifies the dollar amount of the cost adjustment (reduction in expense).

Lines of Worksheet 1 – Supplement 2

Line 1 – LARC Devices

LARC devices are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 2 – Inpatient Hospital

Services provided in an inpatient setting are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 3 – Dental – Outpatient Hospital

Dental services provided in an outpatient hospital setting are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 4 – Prenatal Plus Program

The Prenatal Plus Program is reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 5 – Nurse Home Visitor Program

The Nurse Home Visitor Program is reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 6 – Offsite Lab/X-Ray/Specialty

Patient visits for laboratory, radiology, and specialty care are typically billed to Medicaid by the provider of the service. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8. However, if the FQHC can demonstrate through contract with the off-site laboratory, radiology, or specialty care clinic that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with those services should be included in Worksheet 1, Section A.

Line 7 – ACC PMPM Revenue

FQHCs that participate with one of Colorado Medicaid’s Accountable Care Collaboratives (ACC) are paid a per member per month (PMPM) fee for each patient enrolled in the ACC. The ACC PMPM payment is provided to FQHCs as a Primary Care Medical Provider. Department funds can only be used for activities impacting the Medicaid population. The FQHC cannot use PMPM funds to impact non-Medicaid patients. Any funds determined to be used for only non-Medicaid patient activities will be recovered.

Beginning July 1, 2018, these PMPM payments are made by the RAE to the FQHC at a base amount of \$2 per patient enrolled in the ACC. The PMPM shall not be considered when calculating the per-visit encounter rate provided for in 10 CCR 2505-10 8.700.6. If the FQHC utilizes the funds on Medicaid-covered services, costs up to but not exceeding the received PMPM funds must be excluded from the cost report. For payments beginning July 1, 2018, the FQHC is not required to offset any PMPM payments above the base \$2 PMPM paid by the ACC RAE to FQHCs.

PMPM costs do not need to be offset if the FQHC can demonstrate it is spending the PMPM on unallowable expenses. Appropriate unallowable costs where the PMPM amounts may be spent could include (but are not limited to): clinical pharmacists, housing coordinator, meal programs, community health workers, or other services not covered by Medicaid that support the FQHC in being a medical home.

If the FQHC cannot demonstrate the use of the PMPM on appropriate unallowable services/expenses associated with the Medicaid population, then funds (ACC-attributed enrollees x monthly PMPM) are used as a proxy for expense, and are applied as a reduction of allowable expense.

The FQHC can provide a signed written document (The ACC PMPM Appendix) that includes a copy of their contract language with the Regional Accountable Entity (or Entities) describing the expected uses of the PMPM. The document should also include details on activities and costs justifying the amount of the base amount PMPM of \$2 per patient enrolled in the ACC that were used for activities and services that support the provision of Medical Home level of care or were otherwise included in the unallowable costs in the cost report. The details must include a brief description of how the activity listed falls under the general expectations outlined in the contract with the Regional Accountable Entity (or Entities).

In order to support the assertion that the FQHC spent the \$2 base PMPM on unallowable costs, the FQHC must maintain documentation demonstrating how the accounting system tracks expenditures associated with the \$2 base PMPM, versus all other revenue received by the FQHC. In addition, the FQHC must maintain calculations demonstrating how the expenditures associated with the \$2 base PMPM were determined. This includes, but is not limited to, identification of specific expenditures by working trial balance account and amount, justification for how each expenditure supports activities and services described in the signed written document (referenced above), as well as calculation(s) apportioning the identified unallowable expenditures between the Medicaid and non-Medicaid populations.

Line 8 – Medicaid Grants

Revenue received as part of a Medicaid grant for Medicaid client services must be adjusted off in Column 8 to prevent duplicative payment by the Medicaid program.

Line 9 – Lobbying

Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 10 – Bad Debt

Bad debt expense is unallowable and must be adjusted off.

Line 11 – In-Kind/Donated Costs

The costs of in-kind services or donations received by the FQHC (e.g. rent, supplies, equipment, staff time, etc.) are unallowable and must be adjusted off. However, costs associated with maintaining donated equipment are allowable and should remain in Worksheet 1.

Line 12 – Miscellaneous Income

Some types of miscellaneous income must be offset against expense. Miscellaneous income is defined as income not directly related to patient care and includes items such as expense rebates, medical records copy fees, etc. The amount of the adjustment should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 13 – Interest Income

Interest income must be offset against interest expense, up to the amount of interest expense. The amount of the adjustment should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 14 – Lease Income

Lease income must be adjusted out of the cost report and should be offset against facility costs.

Lines 15-30 – Other (Specify)

There are a number of blank lines on Worksheet 1 – Supplement 2 – Adjustments to Expenses for reporting of other adjustments specific to each FQHC.

Line 31 – Total

This is the total amount of all adjustments entered in Column 3 – Amount. Once all adjustments have been entered on Worksheet 1 – Supplement 2, each adjustment amount must be entered in Column 8 (Adjustments) of Worksheet 1.

WORKSHEET 2

Allocation of Expenses

This form is designed to summarize the expense allocations reported on Worksheet 1. This form automatically pulls data from Worksheet 1 and calculates totals.

Part A – Allocation of Covered Health Care Costs

- Line 1** Total covered health care costs directly attributed to the Physical Health Rate from Worksheet 1, Column 9, sum of Lines 1 through 27.
- Line 2** Total covered health care costs directly attributed to the Dental Health Rate from Worksheet 1, Column 9, sum of Lines 28 through 34.
- Line 3** Total covered health care costs directly attributed to the Specialty Behavioral Health Rate from Worksheet 1, Column 9, sum of Lines 35 through 40.
- Line 4** Total covered health care costs directly attributed to the specific rate from Worksheet 1, Column 9, sum of Lines 1 through 40.
- Line 5** Calculates the percentage of directly attributed covered health care costs that are attributed to the Physical Health Rate. Line 1 divided by Line 4.
- Line 6** Calculates the percentage of directly attributed covered health care costs that are attributed to the Dental Health Rate. Line 2 divided by Line 4.
- Line 7** Calculates the percentage of directly attributed covered health care costs that are attributed to the Specialty Behavioral Health Rate. Line 3 divided by Line 4.
- Line 8** Total covered health care costs to be allocated from Worksheet 1, Column 9, sum of Lines 41 through 46.
- Line 9** Calculates the covered health care costs to be allocated to the Physical Health Rate. Line 5 multiplied by Line 8.
- Line 10** Calculates the covered health care costs to be allocated to the Dental Health Rate. Line 6 multiplied by Line 8.
- Line 11** Calculates the covered health care costs to be allocated to the Specialty Behavioral Health Rate. Line 7 multiplied by Line 8.
- Line 12** Calculates the total covered health care costs for the Physical Health Rate. The sum of Line 1 and Line 9.

Line 13 Calculates the total covered health care costs for the Dental Health Rate. The sum of Line 2 and Line 10.

Line 14 Calculates the total covered health care costs for the Specialty Behavioral Health Rate. The sum of Line 3 and Line 11.

Part B-Allocation of Overhead Costs

Line 15 Total covered health care costs directly attributed to the Physical Health Rate from Line 12 above.

Line 16 Total covered health care costs directly attributed to the Dental Health Rate from Line 13 above.

Line 17 Total covered health care costs directly attributed to the Specialty Behavioral Health Rate from Line 14 above.

Line 18 Total non-reimbursable costs from Worksheet 1, Column 9, Line 63.

Line 19 Calculates the total of all costs excluding overhead costs. The sum of Line 15 through Line 18.

Line 20 Calculates the percentage of total covered health care costs for the Physical Health Rate as a portion of all costs excluding overhead. Line 15 divided by Line 19.

Line 21 Calculates the percentage of total covered health care costs for the Dental Health Rate as a portion of all costs excluding overhead. Line 16 divided by Line 19.

Line 22 Calculates the percentage of total covered health care costs for the Specialty Behavioral Health Rate as a portion of all costs excluding overhead. Line 17 divided by Line 19.

Line 23 Total overhead costs from Worksheet 1, Column 9, Line 89.

Line 24 Calculates the overhead costs that are applicable to the Physical Health Rate. Line 20 multiplied by Line 23.

Line 25 Calculates the overhead costs that are applicable to the Dental Health Rate. Line 21 multiplied by Line 23.

Line 26 Calculates the overhead costs that are applicable to the Specialty Behavioral Health Rate. Line 22 multiplied by Line 23.

Line 27 Calculates the total costs for the Physical Health Rate. The sum of Line 15 and Line 24.

Line 28 Calculates the total costs for the Dental Health Rate. The sum of Line 16 and Line 25.

Line 29 Calculates the total costs for the Specialty Behavioral Health Rate. The sum of Line 17 and Line 26.

Line 30 Calculates the combined costs for the Physical Health, Dental Health, and Specialty Behavioral Health services (i.e. the combined cost of FQHC services). The sum of Lines 27 through 29. These will be the costs incorporated into the FQHC's All-Inclusive Rate.

WORKSHEET 3

FQHC Provider Staff, Visits and Productivity

This form identifies the full time equivalent (FTE) of physicians, mid-levels, and other provider staff, and the number of visits delivered by each provider category during the reporting period. It also applies a productivity standard to medical providers to determine whether actual visits or expected productivity standard visits will be used in the rate calculation.

Part A – FQHC Provider Staff and Visits

Columns of Part A – FQHC Provider Staff and Visits

Columns 1-4

These columns calculate the total number of FTEs based on the FQHC's normal hours for full-time employment. Note that 2,080 is the maximum number of paid hours to be considered full-time. The FTE for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time, per the [Medicare Benefit Policy Manual, Chapter 13](#), Part 70.4. For providers who deliver health care services on an inpatient basis (hospital rounds), only the FTE relative to the delivery of outpatient services should be reported. The FTE relative to the inpatient services is not reported as these services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate.

Column 1 – FTE Personnel – Contract

This column identifies the total number of FTEs contracted by the FQHC.

Column 2 – FTE Personnel – Volunteer

This column identifies the total number of FTEs that work on a volunteer basis at the FQHC.

Column 3 – FTE Personnel – Staff

This column identifies the total number of FTEs that are employed and paid by the FQHC.

Column 4 – FTE Personnel – Total

This column calculates the total number of FTEs for each provider category.

Personnel records, contracts and agreements in support of reported FTE must be documented and maintained for review.

FTEs for non-provider staff should also be calculated by position using the same methodology as outlined above. These amounts are reported on a separate auxiliary schedule. See example in *Appendix B*.

Columns 5-7

These columns identify the visits by provider type. "Visit" means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker.

Group sessions do not generate a billable encounter for any FQHC services (10 CCR 2505-10 8.700.1). Effective July 1, 2018, the definition of a visit was expanded to include encounters with licensed marriage and family therapists, licensed professional counselors and licensed addiction counselors, in addition to the providers previously listed.

All visits must be reported, even those for which the FQHC is unable to collect a payment or chooses not to bill for the service. Visits delivered in an inpatient hospital setting for medical services, dentures visits for, and visits delivered in an outpatient hospital setting for dental services are **not** reported in the cost report as these services are paid to the FQHC on a fee-for-service basis rather than part of the encounter rate. Dental services that require multiple visits and are paid as one visit shall be counted as only one visit in the cost report.

Column 5 – Visits – On-Site

This column identifies the total number of visits delivered at a clinic site operated by the FQHC directly.

Column 6 – Visits – Off-Site

This column identifies the total number of visits delivered to FQHC clients at a site not directly operated by the FQHC, such as a nursing facility.

Column 7 – Total Visits

This column calculates the total number of visits for each provider category.

Lines of Part A – FQHC Provider Staff and Visits

The lines of Worksheet 3 identify the providers approved by the State of Colorado for which FTE and visits data is presented. Only those providers approved by the State of Colorado per 10 CCR 2505-10 (physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor, and behavioral health masters level candidates for licensure) are to be reported on Worksheet 3.

Lines 1-3

These lines identify the FTEs and visits for medical providers (physicians, physician assistants, nurse practitioners, and certified nurse midwives) included in the physical health rate. These subtotals will be used in the productivity standard calculations in Part B of Worksheet 3.

Lines 4-9

These lines identify the FTEs and visits for other providers included in the physical health rate. If applicable, the FTE and visits associated with interns and residents are reported in Line 9 – Other.

Lines 10-11

These lines identify the FTEs and visits for dental health providers included in the dental health rate.

Lines 12-14

These lines identify the FTEs and visits for behavioral health providers included in the specialty behavioral health rate.

Line 15

Calculates the total FTEs and visits.

Part B – Minimum Medical Team Productivity

Productivity Standards

The State applies a minimum standard of productivity for rate determinations:

- 4,200 encounters for each FTE physician
- 2,100 encounters for each FTE non-physician practitioner

Part B of Worksheet 3 applies this productivity standard to the FTE reported by the FQHC in Part A and determines whether actual visits or productivity standard visits will be used in the rate calculation.

Line 16 Total number of visits delivered by medical providers from Part A, Column 7, Line 3.

Line 17 Total medical provider FTE for the minimum medical team productivity standard calculation, which is 100% of the physician FTE reported in Part A, Column 4, Line 1 plus 50% of the mid-level FTE reported in Part A, Column 4, Lines 2 through 2.3.

Line 18 Calculates the minimum medical team productivity by multiplying Part B, Line 17 by 4,200 and enter the result. This is the expected number of visits under the minimum medical team productivity methodology.

Line 19 The medical provider visits to be used in rate determination, which is the greater of Part B, Line 16 or Line 18.

Exception to Productivity Standards

Productivity standards established by the State of Colorado are guidelines that reflect the total combined services of the staff. If the FQHC does not meet the productivity standards, an exception may be granted based upon specific circumstances. Examples of reasons for not meeting the productivity standards include the following: newly designated FQHC entities, newly established FQHC sites, new FQHC provider staff with low volume, an FQHC that provides the majority of services to special populations, implementation of an electronic medical record, etc.

Part C – Provider Visits for Rate Determination

This section calculates the number of provider visits that will be used in the FQHC rate determination.

Line 20 The total of all physical health provider visits to be used in the Physical Health Rate, which is the sum of Line 19 and Column 7, Lines 4 through 9.

Line 21 The total of all dental health provider visits to be used in the Dental Health Rate, which is the sum of Column 7, Lines 10 through 11.

Line 22 The total of all specialty behavioral health provider visits to be used in the Specialty Behavioral Health Rate, which is the sum of Column 7, Lines 12 through 14.

Line 23 Calculates the combined FQHC visits for the rate determination, which is the sum of Lines 20 through 22. These will be the visits incorporated into the FQHC's All-Inclusive Rate.

WORKSHEET 4

Determination of FQHC Encounter Rates

This form is designed to bring together information on all the other forms in order to determine the FQHC's rates. This form automatically pulls data from various other worksheets and calculates totals.

Part A – All-Inclusive Rate

- Line 1** The combined costs for the Physical Health, Dental Health, and Specialty Behavioral Health Rate services (i.e. the combined cost of FQHC services) from Worksheet 2, Line 30.
- Line 2** The combined provider visits for the rate determination from Worksheet 3, Line 23.
- Line 3** Calculates the uninflated Current Year Calculated All-Inclusive Rate. Line 1 divided by Line 2.
- Line 4** Calculates the FQHC inflation factor. Line 3 multiplied by the applicable MEI.
- Line 5** Calculates the Current Year Calculated Inflated All-Inclusive Rate. The sum of Line 3 and Line 4.
- Line 6** Current Year Inflated All-Inclusive Base Rate (entered by the Department's contractor).
- Line 7** Calculates the Alternative Payment Methodology All-Inclusive Rate. The lower of Line 5 and Line 6.
- Line 8** The Inflated PPS Rate (entered by the Department's contractor).
- Line 9** Calculates the final All-Inclusive Encounter Rate. The higher of Line 7 and Line 8.

Part B – Physical Health Rate

- Line 10** The total costs for the Physical Health Rate from Worksheet 2, Line 27.
- Line 11** The total provider visits for the Physical Health Rate determination from Worksheet 3, Line 20.
- Line 12** Calculates the uninflated Current Year Calculated Physical Health Rate. Line 10 divided by Line 11.
- Line 13** Calculates the FQHC inflation factor. Line 12 multiplied by the applicable MEI.

- Line 14** Calculates the Current Year Calculated Inflated Physical Health Rate. The sum of Line 12 and Line 13.
- Line 15** The Current Year Inflated Physical Health Base Rate (entered by the Department’s contractor).
- Line 16** Calculates the Alternative Payment Methodology Physical Health Rate. The lower of Line 14 and Line 15.
- Line 17** The Quality Component reduction (entered by the Department’s contractor).
- Line 18** Calculates the final Physical Health Encounter Rate. Line 16 reduced by Line 17.

Part C – Dental Health Rate

- Line 19** The total costs for the Dental Health Rate from Worksheet 2, Line 28.
- Line 20** The total provider visits for the Dental Health Rate determination from Worksheet 3, Line 21.
- Line 21** Calculates the uninflated Current Year Calculated Dental Health Rate. Line 19 divided by Line 20.
- Line 22** Calculates the FQHC inflation factor. Line 21 multiplied by the applicable MEI.
- Line 23** Calculates the Current Year Calculated Inflated Dental Health Rate. The sum of Line 21 and Line 22.
- Line 24** The Current Year Inflated Dental Health Base Rate (entered by the Department’s contractor).
- Line 25** Calculates the Alternative Payment Methodology Dental Health Rate. The lower of Line 23 and Line 24.
- Line 26** The final Dental Health Encounter Rate. This is Line 25.

Part D – Specialty Behavioral Health Rate

- Line 27** The total costs for the Specialty Behavioral Health Rate from Worksheet 2, Line 29.
- Line 28** The total provider visits for the Specialty Behavioral Health Rate determination from Worksheet 3, Line 22.
- Line 29** Calculates the uninflated Current Year Calculated Specialty Behavioral Health Rate. Line 27 divided by Line 28.

- Line 30** Calculates the FQHC inflation factor. Line 29 multiplied by the applicable MEI.
- Line 31** Calculates the Current Year Calculated Inflated Specialty Behavioral Health Rate. The sum of Line 29 and Line 30.
- Line 32** The Current Year Inflated Specialty Behavioral Health Base Rate (entered by the Department's contractor).
- Line 33** Calculates the Alternative Payment Methodology Specialty Behavioral Health Rate. The lower of Line 31 and Line 32.
- Line 34** The Quality Component reduction (entered by the Department's contractor).
- Line 35** Calculates the final Specialty Behavioral Health Encounter Rate. Line 33 reduced by Line 34.

Part E – Physical Health Payment Per Member Per Month

This section is for FQHCs that participate in the Per Member Per Month (PMPM) pilot program. This section is not to be completed by the FQHC, as the State of Colorado will provide the necessary data and perform the final calculation.

ADDENDUM 1

Encounter Report

Addendum 1 is designed for the FQHC to report the total visits reported on Worksheet 3 in several different groupings.

Sections of Addendum 1

Encounters

This section identifies the total number of Medicaid encounters and the total number of overall encounters. The total encounters must include all behavioral health encounters (including both the six Short Term Behavioral Health visits and visits reimbursed through the RAEs), CHP+ encounters, HMO encounters, dental encounters, and all other encounters.

Dental Encounters

This section identifies dental encounters, both Medicaid and total. Delta Dental CHP+ encounters are included in this section.

Encounter Type

This column identifies the names of the payer.

Column 1 – Medicaid/CHP+ Encounters

This column identifies all Medicaid and CHP+ client encounters that correspond with each payer. These are all claims that are eligible to be paid at the FQHC encounter rates.

Column 2 – Total Encounters

This column identifies the total encounters that correspond with each payer.

Physical Health Encounters

This section identifies Physical Health encounters, including Medicaid, HMO, and CHP+ encounters by payer. The columns are completed similarly to that detailed in the Dental Encounters section above.

Behavioral Health Encounters

This section identifies all behavioral health encounters.

Lines 18-24

These lines identify the Medicaid and total RAE/STBH encounters. The columns are completed similarly to that detailed in the Dental Encounters section above.

Line 25

This line automatically calculates the total /RAE/STBH encounters.

Line 26

This line identifies the Medicaid and total non- RAE/STBH behavioral health encounters.

Line 27

This line automatically calculates the total RAE/STBH and non-RAE/STBH behavioral health encounters.

Encounter Variance

The sixth section of this form automatically calculates the variance in total encounters.

Line 28

Automatically calculates the total number of encounters. This should be the same as the total encounters on Worksheet 3, Column 7, Line 15 (which has been carried over to Line 25 here).

Line 29

Automatically calculates the variance between Line 24 and Line 25.

Line 30

Variances must be explained in this section.

ADDENDUM 2

Unallowable Expenses

Unallowable costs are defined in the Worksheet 1 section of these instructions. They include, but are not limited to, expenses that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per-visit encounter rate for Medicaid clients (10 CCR 2505-10 8.700.5.B).

Addendum 2 is provided so that the FQHC can determine if unallowable costs have been incurred and the associated dollar amount to be adjusted out of the expenses on Worksheet 1. All expenses noted in this Addendum must be transferred to Worksheet 1 – Supplement 2.

A response of “yes” or “no” is selected for each expense category shown to indicate if the expense was incurred during the reporting period. The dollar amount and general ledger account number are identified for each unallowable expense incurred.

Lines of Addendum 2

Line 1 – Alcoholic Beverages

The cost of alcoholic beverages of any kind are unallowable. This includes social events that may be hosted by the FQHC as well as alcoholic beverages purchased by employees traveling on business.

Line 2 – Lobbying Expense

Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable.

Line 3 – Gifts and Donations

The cost related to the FQHC giving gifts and donations to other entities or people is unallowable. Examples include donations to Local Fun Runs, donations in lieu of flowers, etc. This should align with Line 83 on Worksheet 1.

Line 4 – Volunteers and Donated Services, Goods, or Space

The value of volunteers and donated services is not reimbursable as a cost, regardless of the service donated. The value of any donated goods or space is not reimbursable as a cost.

Line 5 – Sports and Other Tickets

The cost incurred by the FQHC for any type of sporting or other tickets is unallowable.

Line 6 – Other Entertainment

The cost incurred by the FQHC for any other type of entertainment besides sports and other tickets is unallowable.

Line 7 – Country Club Dues

The cost of country club dues paid on behalf of the FQHC or any of its employees is unallowable.

Line 8 – Educational Expenses for Spouse or Other Relatives

The costs to pay for educational expenses of spouses or other relatives of the FQHC’s employees are unallowable.

Line 9 – Costs Incurred on Behalf of Related Organizations

Any costs incurred on behalf of an organization related to the FQHC are unallowable.

Line 10 – Costs Associated with Reorganizations, Mergers, Acquisitions, etc.

Costs incurred by the FQHC related to reorganizations, mergers, or acquisitions are unallowable.

Line 11 – Cost of Travel Incurred in Connection with Non-patient Care Related Purposes

Travel costs that are not related to patient care are unallowable.

Line 12 – Personal Use of Autos

The cost of personal use of a company vehicle is unallowable. For example, if an employee maintains use of a company vehicle for business and personal use, and is taxed on the personal use at the end of each tax year, the cost related to the personal use must be removed from the cost report as unallowable.

Line 13 – Housing and Personal Living Expenses

Costs of housing, housing allowances, and personal living expenses for any of the FQHC’s officers or employees are unallowable.

Line 14 – Patient Incentives

Costs of incentives given to patients for visiting the clinic are unallowable. These include rewards given to children for visiting the pediatric portions of the clinic.

Line 15 – Reach Out and Read Expenses

Costs associated with the program Reach Out and Read, or any such similar program, are unallowable.

Line 16 – Fines and Penalties

Costs associated with fines or penalties of any kind are unallowable.

Line 17 – Miscellaneous Income

Miscellaneous income generated from services that are not directly related to patient care (such as medical records copy fees, etc.) must be offset against the associated expense. Additionally, rebates, refunds and credits must be applied as a reduction to the associated expense.

Line 18 – Interest Income

Interest income earned must be offset against interest expense, up to the amount of interest expense.

Lines 19-30 – Other (Specify)

Any other unallowable costs incurred by the FQHC are reported under “Other” with an explanation of the cost.

Line 31 – Total

Automatically calculates the total unallowable expense reported in Line 1 through Line 30.

ADDENDUM 3

Administration Breakdown

This form provides for a breakdown of the overhead costs reported on Worksheet 1, Line 64 – Administration. All administration costs should be included in as much detail as possible. If any costs are identified in the Administration Breakdown that belong under other lines in the Cost Report, these costs will be moved to the appropriate line.

Columns of Addendum 3

Explanation of Entry

This column contains the description of the cost included in Worksheet 1, Line 64 – Administration.

Column

This column identifies the column in which the cost was originally reported on Worksheet 1. For the purposes of this Addendum, the columns include:

1. Compensation,
2. Fringe Benefits,
3. Purchased & Contracted Services, and
4. Other.

Amount

This column identifies the amount included in Worksheet 1, Line 64 – Administration for the specific cost.

Lines of Addendum 3

Lines 1 – 100

Each line identifies a specific cost that is included in Worksheet 1, Line 64 – Administration. Use as many lines as needed. If the amount of lines is not adequate for the number of administrative costs, similar costs may be consolidated into one line.

Line 101 – Total

This line automatically calculates the total amount of all administrative costs reported in Column 3 – Amount. The total amount should be equal to Worksheet 1, Line 64, Column 5 - Total.

APPENDIX A

FQHC Cost Report Forms

All FQHCs will receive updated electronic versions of these spreadsheets annually. Documents included here are only for reference and are not to be submitted.

 COLORADO Department of Health Care Policy & Financing	
COLORADO MEDICAID FEDERALLY QUALIFIED HEALTH CENTER (FQHC) STATISTICAL DATA AND CERTIFICATION FORM	
1. Cost Report Submission and FQHC Data	
Date Submitted: _____ Date Received: _____ FQHC Name: _____ Street: _____ City: _____ County: _____ State: _____ Zip Code: _____ Phone Number: _____ Fax Number: _____ E-mail: _____	
2. FQHC National Provider Identifier Numbers (continue on tab 2 as necessary)	
FQHC Site NPI Number	Corresponding Medicaid ID
3. Reporting Period	
Reporting Period Begin: _____ Reporting Period End: _____	
4. Type of Control (Choose one.)	
Voluntary Non-Profit: _____ Proprietary: _____ Government: _____ Other: _____	
5. Other Federally Qualified Health Centers, Providers of Service including Rural Health Clinics, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Suppliers or Other Entities that are owned or related through Common Ownership or Control to the Individual or Entity:	
Clinic or Provider Number	Provider Name, Location
6. Source of Federal Funds (Choose all that apply.)	
Community Health Center (Section 330(d), Public Health Service Act): _____ Migrant Health Center (Section 329(d), Public Health Service Act): _____ Health Services for the Homeless (Section 340(d), Public Health Service Act): _____ Other: _____	
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC	
I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by: _____	
for the cost report period listed above in Item 3 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the FQHC in accordance with applicable State rules/instructions except as noted: _____	
Signature (Officer or Administrator of FQHC) _____	
Print Name of Signing Officer or Administrator _____	
Title	Date

NPI Number:
 Reporting Period Begin: 1/0/00
 Reporting Period End: 1/0/00
 Type of Data:

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES - Worksheet 1, Page 1

Cost Center	1. Compensation	2. Fringe Benefits	3. Purchased & Contract Services	4. Other	5. Total (Column 1 through Column 4)	6. Reclassifications (from tab Worksheet 1 Supplement 1)	7. Reclassified Trial Balance (Columns 5+6)	8. Adjustments Increase or (Decrease) (from tab Worksheet 1 Supplement 2)	9. Net Expenses (Columns 7+8)
A. Covered Health Care Costs									
Subsection 1. Physical Health Rate									
1. Physicians					0		0		0
2. Physicians Assistants					0		0		0
3. Nurse Practitioners					0		0		0
4. Nurse Midwife					0		0		0
5. Podiatrists					0		0		0
6. Other Nurses (RN/LPN)					0		0		0
7. Medical Assistants/Nurse Aides					0		0		0
8. Interns/Residents					0		0		0
9. Psychiatrist (Non-RAE/STBH Services)					0		0		0
10. Licensed Clinical Psychologists (Non-RAE/STBH Services)					0		0		0
11. Licensed Clinical Social Workers (Non-RAE/STBH Services)					0		0		0
12. Other Licensed Behavioral Health Providers (Non-RAE/STBH Services)					0		0		0
13. Other Behavioral Health Providers (Non-RAE/STBH Services)					0		0		0
14. Laboratory Medical					0		0		0
15. X-Ray Medical					0		0		0
16. Physical Therapy					0		0		0
17. Occupational Therapy					0		0		0
18. Vocational Therapy					0		0		0
19. Speech Pathology					0		0		0
20. Health Education					0		0		0
21. Medical Supplies					0		0		0
22. Optometry Supplies					0		0		0
23. Pharmaceuticals Incident to a Service					0		0		0
24. Medical Small Equipment					0		0		0
25. Medical Equipment Repairs & Maintenance					0		0		0
26. Malpractice - Physician					0		0		0
27. Other (Specify):					0		0		0
Subsection 2. Dental Health Rate									
28. Dentists					0		0		0
29. Dental Hygienists					0		0		0
30. Dental Assistants					0		0		0
31. Dental Laboratory and Supplies					0		0		0
32. Dental Small Equipment					0		0		0
33. Dental Equipment Repairs & Maintenance					0		0		0
34. Other (Specify):					0		0		0
Subsection 3. Specialty Behavioral Health Rate									
35. Psychiatrists					0		0		0
36. Licensed Clinical Psychologists					0		0		0
37. Licensed Clinical Social Workers					0		0		0
38. Other Licensed Behavioral Health Providers					0		0		0
39. Other Behavioral Health Providers					0		0		0
40. Other (Specify):					0		0		0
Subsection 4. Costs to be Allocated across All Rates									
41. Medical Records					0		0		0
42. Translation					0		0		0
43. Patient Transportation					0		0		0
44. Case Management					0		0		0
45. Outstationing					0		0		0
46. Other (Specify):					0		0		0
47. Total Covered Health Care Costs (lines 1 through 46)	0	0	0	0	0	0	0	0	0

NPI Number: _____
 Reporting Period Begin: 1/0/00
 Reporting Period End: 1/0/00
 Type of Data: _____

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES - Worksheet 1, Page 2

Cost Center	1. Compensation	2. Fringe Benefits	3. Purchased & Contract Services	4. Other	5. Total (Column 1 through Column 4)	6. Reclassifications (from tab Worksheet 1 Supplement 1)	7. Reclassified Trial Balance (Columns 5+6)	8. Adjustments Increase or (Decrease) (from tab Worksheet 1 Supplement 2)	9. Net Expenses (Columns 7+8)
B. Non-Reimbursable Costs									
Subsection 1. Services Reimbursed Outside of the Cost Report									
48. Pharmacy					0		0		0
49. LARC devices					0		0	0	0
50. Inpatient Hospital					0		0	0	0
51. Dentures and Partial Dentures					0		0	0	0
52. Dental Services in an Outpatient Hospital Setting					0		0	0	0
53. Prenatal Plus Program					0		0	0	0
54. Nurse Home Visitor Program					0		0	0	0
55. Offsite Laboratory/X-Ray/Specialty Care Office Visits					0		0	0	0
56. Other (Specify):					0		0		0
Subsection 2. Non-Reimbursable Services									
57. Services Not Covered by Colorado Medicaid					0		0		0
58. Marketing					0		0		0
59. Unallowable Outreach					0		0		0
60. Fundraising					0		0		0
61. Grant Writing					0		0		0
62. Other (Specify):					0		0		0
63. Total Non-Reimbursable Costs (lines 48 through 62)	0	0	0	0	0	0	0	0	0
C. Overhead Costs									
64. Administration					0		0		0
65. Call Center/Reception					0		0		0
66. Quality & Compliance					0		0		0
67. Finance					0		0		0
68. Information Technology (IT)					0		0		0
69. Billing and Coding					0		0		0
70. Legal					0		0		0
71. Housekeeping					0		0		0
72. Small Equipment, Maintenance/Repair					0		0		0
73. Security					0		0		0
74. Supplies					0		0		0
75. Insurance					0		0		0
76. Malpractice-Clinic					0		0		0
77. Allowable Advertising, Outreach and Public Relations					0		0		0
78. Telephone					0		0		0
79. Utilities					0		0		0
80. Rent					0		0		0
81. Depreciation					0		0		0
82. Amortization					0		0		0
83. Contributions					0		0		0
84. Travel and Transportation					0		0		0
85. Mortgage Interest					0		0		0
86. Property Tax					0		0		0
87. Human Resources					0		0		0
88. Other (Specify):					0		0		0
89. Total Overhead Costs (lines 64 through 87)	0	0	0	0	0	0	0	0	0
D. Total Costs (sum of sections A, B, and C)	0	0	0	0	0	0	0	0	0

NPI Number: _____
 Reporting Period Begin: 1/0/00 _____
 Reporting Period End: 1/0/00 _____
 Type of Data: _____

RECLASSIFICATIONS - Worksheet 1, Supplement 1

Entry Number	Explanation of Entry	1. Code	2. W/S 1 Cost Center	3. W/S 1 Line Number	4. Amount*	5. W/S 1 Cost Center	6. W/S 1 Line Number	7. Amount*
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34								
35								
36	Total Reclassifications (sum of column 4 must equal sum of column 7)				0			0

* Note: Amount must agree to W/S 1, column 6 line, as appropriate.

NPI Number: _____
 Reporting _____
 Period Begin: 1/0/00 _____
 Reporting _____
 Period End: 1/0/00 _____

Type of Data: _____

ADJUSTMENTS TO EXPENSES - Worksheet 1, Supplement 2*

Explanation of Entry	1. W/S 1 Cost Center	2. W/S 1 Line Number	3. Amount**
1. LARC Devices			
2. Inpatient Hospital			
3. Dental - Outpatient Hospital			
4. Prenatal Plus Program			
5. Nurse Home Visitor Program			
6. Offsite Lab/X-Ray/Specialty			
7. ACC PMPM Offset			
8. Medicaid Grants			
9. Lobbying			
10. Bad Debt			
11. In-Kind/Donated Costs			
12. Miscellaneous Income			
13. Interest Income			
14. Lease Income			
15. Other (Specify):			
16. Other (Specify):			
17. Other (Specify):			
18. Other (Specify):			
19. Other (Specify):			
20. Other (Specify):			
21. Other (Specify):			
22. Other (Specify):			
23. Other (Specify):			
24. Other (Specify):			
25. Other (Specify):			
26. Other (Specify):			
27. Other (Specify):			
28. Other (Specify):			
29. Other (Specify):			
30. Other (Specify):			
31. Total Adjustments			0
Total Adjustment per W/S 1			0
Check Figure Should be Zero			0

* Note: Negative amounts are deducted from Worksheet 1 and positive amounts are added to Worksheet 1.

** Note: Amount must agree to W/S 1, column 8, as appropriate.

NPI Number: _____
 Reporting Period Begin: 1/0/00
 Reporting Period End: 1/0/00
 Type of Data: _____

ALLOCATION OF EXPENSES - Worksheet 2

Note: No facility input necessary on this page.

PART A - ALLOCATION OF COVERED HEALTH CARE COSTS

1. Total Covered Health Care Costs Directly Attributed to the Physical Health Rate (W/S 1, sum of lines 1 through 27)	0
2. Total Covered Health Care Costs Directly Attributed to the Dental Health Rate (W/S 1, sum of lines 28 through 34)	0
3. Total Covered Health Care Costs Directly Attributed to the Specialty Behavioral Health Rate (W/S 1, sum of lines 35 through 40)	0
4. Total Covered Health Care Costs Directly Attributed to a Specific Rate (sum of lines 1 through 3)	0
5. Percentage of Directly Attributed Covered Health Care Costs - Physical Health Rate (line 1 divided by line 4)	#DIV/0!
6. Percentage of Directly Attributed Covered Health Care Costs - Dental Health Rate (line 2 divided by line 4)	#DIV/0!
7. Percentage of Directly Attributed Covered Health Care Costs - Specialty Behavioral Health Rate (line 3 divided by line 4)	#DIV/0!
8. Total Covered Health Care Costs to be Allocated (W/S 1, sum of lines 41 through 46)	0
9. Covered Health Care Costs Allocated to the Physical Health Rate (line 5 multiplied by line 8)	#DIV/0!
10. Covered Health Care Costs Allocated to the Dental Health Rate (line 6 multiplied by line 8)	#DIV/0!
11. Covered Health Care Costs Allocated to the Specialty Behavioral Health Rate (line 7 multiplied by line 8)	#DIV/0!
12. Total Covered Health Care Costs for the Physical Health Rate (sum of line 1 and line 9)	#DIV/0!
13. Total Covered Health Care Costs for the Dental Health Rate (sum of line 2 and line 10)	#DIV/0!
14. Total Covered Health Care Costs for the Specialty Behavioral Health Rate (sum of line 3 and line 11)	#DIV/0!

PART B - ALLOCATION OF OVERHEAD COSTS

15. Total Covered Health Care Costs for the Physical Health Rate (line 12)	#DIV/0!
16. Total Covered Health Care Costs for the Dental Health Rate (line 13)	#DIV/0!
17. Total Covered Health Care Costs for the Specialty Behavioral Health Rate (line 14)	#DIV/0!
18. Total Non-Reimbursable Costs (W/S 1, line 63)	0
19. Total of All Costs Excluding Overhead Costs (sum of line 15 through line 18)	#DIV/0!
20. Percentage of Covered Health Care Costs for the Physical Health Rate (line 15 divided by line 19)	#DIV/0!
21. Percentage of Covered Health Care Costs for the Dental Health Rate (line 16 divided by line 19)	#DIV/0!
22. Percentage of Covered Health Care Costs for the Specialty Behavioral Health Rate (line 17 divided by line 19)	#DIV/0!
23. Total Overhead Costs (W/S 1, line 87)	0
24. Overhead Applicable to the Physical Health Rate (line 20 multiplied by line 23)	#DIV/0!
25. Overhead Applicable to the Dental Health Rate (line 21 multiplied by line 23)	#DIV/0!
26. Overhead Applicable to the Specialty Behavioral Health Rate (line 22 multiplied by line 23)	#DIV/0!
27. Total Costs for the Physical Health Rate (sum of line 15 and line 24)	#DIV/0!
28. Total Costs for the Dental Health Rate (sum of line 16 and line 25)	#DIV/0!
29. Total Costs for the Specialty Behavioral Health Rate (sum of line 17 and line 26)	#DIV/0!
30. Combined Costs for Physical Health, Dental Health, and Specialty Behavioral Health Services (sum of lines 27 through 29)	#DIV/0!

NPI Number: _____
 Reporting
 Period Begin: 1/0/00
 Reporting
 Period End: 1/0/00
 Type of Data: _____

FQHC PROVIDER STAFF, VISITS AND PRODUCTIVITY - Worksheet 3

PART A - FQHC PROVIDER STAFF AND VISITS

Position	1. FTE Personnel - Contract	2. FTE Personnel - Volunteer	3. FTE Personnel - Staff	4. FTE Personnel - Total	5. Visits - On-Site	6. Visits - Off-Site	7. Visits - Total
Physical Health Visits							
1. Physicians				0.00			0
2.1 Physician Assistants				0.00			0
2.2 Nurse Practitioners				0.00			0
2.3 Certified Nurse Midwives				0.00			0
3. Subtotal	0.00	0.00	0.00	0.00	0	0	0
4. Podiatrist				0.00			0
5. Psychiatrists/Psychologists - Non-RAE/STBH Services				0.00			0
6. Clinical Social Workers - Non-RAE/STBH Services				0.00			0
7. Other Behavioral Health Workers - Non-RAE/STBH Svcs.				0.00			0
8. Locum Tenens Providers				0.00			0
9. Other (Specify)				0.00			0
Dental Health Visits							
10. Dentists				0.00			0
11. Dental Hygienists				0.00			0
Specialty Behavioral Health Visits							
12. Psychiatrists/Psychologists - Capitation Services				0.00			0
13. Clinical Social Workers - Capitation Services				0.00			0
14. Other Behavioral Health Workers - Capitation Services				0.00			0
15. Total	0.00	0.00	0.00	0.00	0	0	0

PART B - MINIMUM MEDICAL TEAM PRODUCTIVITY

16. Total Medical Team Visits (column 7, line 3)	0
17. Total Medical Team FTEs (column 4, line 1 plus 1/2 sum of lines 2.1, 2.2, and 2.3)	0.00
18. Minimum Medical Team Productivity (line 17 times 4,200)	0
19. Medical Team Visits to be Used in Rate Determination (greater of line 16 and line 18)	0

PART C - PROVIDER VISITS FOR RATE DETERMINATION

20. Total Provider Visits for Physical Health Rate determination (sum of line 19 and column 7, lines 4 through 9)	0
21. Total Provider Visits for Dental Health Rate determination (column 7, sum of lines 10 through 11)	0
22. Total Provider Visits for Specialty Behavioral Health Rate determination (column 7, sum of lines 12 through 14)	0
23. Combined Provider Visits for Rate Determination (sum of lines 20 through 22)	0

NPI Number: _____
 Reporting Period Begin: 1/0/00
 Reporting Period End: 1/0/00
 Type of Data: _____

DETERMINATION OF FQHC ENCOUNTER RATES - Worksheet 4
 Note: No facility input necessary on this page.

PART A - ALL-INCLUSIVE RATE

1. Combined Costs for Physical Health, Dental Health, and Specialty Behavioral Health Services (W/S 2, line 30)	#DIV/0!
2. Combined Provider Visits for Rate Determination (W/S 3, line 23)	0
3. Uninflated Current Year Calculated All-Inclusive Rate (line 1 divided by line 2)	#DIV/0!
4. FQHC Inflation Factor MEI 1.9% [(CMS (CR) #:9348) multiplied by line 3]	#DIV/0!
5. Current Year Calculated Inflated All-Inclusive Rate (sum of line 3 and line 4)	#DIV/0!
6. Current Year Inflated All-Inclusive Base Rate	
7. Alternative Payment Methodology All-Inclusive Rate (lesser of line 5 and line 6)	#DIV/0!
8. Inflated PPS Rate	
9. Final All-Inclusive Encounter Rate (higher of line 7 and line 8)	#DIV/0!

PART B - PHYSICAL HEALTH RATE

10. Total Costs for the Physical Health Rate (W/S 2, line 27)	#DIV/0!
11. Total Provider Visits for Physical Health Rate Determination (W/S 3, line 20)	0
12. Uninflated Current Year Calculated Physical Health Rate (line 10 divided by line 11)	#DIV/0!
13. FQHC Inflation Factor MEI 1.9% [(CMS (CR) #:9348) multiplied by line 12]	#DIV/0!
14. Current Year Calculated Inflated Physical Health Rate (sum of line 12 and line 13)	#DIV/0!
15. Current Year Inflated Physical Health Base Rate	
16. Alternative Payment Methodology Physical Health Rate (lesser of line 14 and line 15)	#DIV/0!
17. Quality Component Reduction - NOT APPLICABLE IN THE CURRENT YEAR	
18. Final Physical Health Encounter Rate (line 16 reduced by line 17)	#DIV/0!

PART C - DENTAL HEALTH RATE

19. Total Costs for the Dental Health Rate (W/S 2, line 28)	#DIV/0!
20. Total Provider Visits for Dental Health Rate Determination (W/S 3, line 21)	0
21. Uninflated Current Year Calculated Dental Health Rate (line 19 divided by line 20)	#DIV/0!
22. FQHC Inflation Factor MEI 1.9% [(CMS (CR) #:9348) multiplied by line 21]	#DIV/0!
23. Current Year Calculated Inflated Dental Health Rate (sum of line 21 and line 22)	#DIV/0!
24. Current Year Inflated Dental Health Base Rate	
25. Alternative Payment Methodology Dental Health Rate (lesser of line 23 and line 24)	#DIV/0!
26. Final Dental Health Encounter Rate (line 25)	#DIV/0!

PART D - SPECIALTY BEHAVIORAL HEALTH RATE

27. Total Costs for the Specialty Behavioral Health Rate (W/S 2, line 29)	#DIV/0!
28. Total Provider Visits for Specialty Behavioral Health Rate Determination (W/S 3, line 22)	0
29. Uninflated Current Year Calculated Specialty Behavioral Health Rate (line 27 divided by line 28)	#DIV/0!
30. FQHC Inflation Factor MEI 1.9% [(CMS (CR) #:9348) multiplied by line 29]	#DIV/0!
31. Current Year Calculated Inflated Specialty Behavioral Health Rate (sum of line 29 and line 30)	#DIV/0!
32. Current Year Inflated Specialty Behavioral Health Base Rate	
33. Alternative Payment Methodology Specialty Behavioral Health Rate (lesser of line 31 and line 32)	#DIV/0!
34. Quality Component reduction - NOT APPLICABLE IN THE CURRENT YEAR	
35. Final Specialty Behavioral Health Encounter Rate (line 33 reduced by line 34)	#DIV/0!

PART E - PHYSICAL HEALTH PAYMENT PER MEMBER PER MONTH

36. Final Physical Health Encounter Rate (line 18)	#DIV/0!
37. Provider Prior Year Attributed Physical Health Revenue	
38. Total Member Months for Attributed Members	
39. Per Member Per Month Adjustment Factor	
40. Final Physical Health Payment Per Member Per Month	#DIV/0!

NPI Number: _____
 Reporting
 Period Begin: 1/0/00
 Reporting
 Period End: 1/0/00

Type of Data: _____

ENCOUNTER REPORT - Addendum 1

ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
1. Total Encounters		

DENTAL ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
2.		
3.		
4.		
5.		

PHYSICAL HEALTH ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16. Total Physical Health Encounters	0	0

BEHAVIORAL HEALTH ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24. Total STBI/VRAE Encounters	0	0
25. Non-STBI/VRAE Behavioral Health Encounters		
26. Total Behavioral Health Encounters	0	0

ENCOUNTER VARIANCE

27. Total Encounters (column 2, line 1)	0
28. Total Encounters (W/S 3: col 7, line 15)	0
29. Variance	0

30. If there is a variance, please explain in the cell below:

NPI Number: _____
 Reporting Period Begin: 1/0/00
 Reporting Period End: 1/0/00

Type of Data: _____

UNALLOWABLE EXPENSES - Addendum 2

EXAMPLE OF UNALLOWABLE EXPENSE FOR MEDICAID COST REPORTS

Expense	Yes	No	If Yes, State Amount	General Ledger Account #
1. Alcoholic Beverages				
2. Lobbying Expense (including a portion of CCHN Dues)				
3. Gifts and Donations				
4. Volunteers and Donated Services, Goods, or Space				
5. Sports and Other Tickets				
6. Other Entertainment				
7. Country Club Dues				
8. Education Expenses for Spouse or Other Relatives				
9. Costs Incurred on Behalf of Related Organizations				
10. Costs Associated with Reorganizations, Mergers, Acquisitions, etc.				
11. Cost of Travel Incurred in Connection with Non-patient Care Related Purposes				
12. Personal Use of Autos				
13. Housing and Personal Living Expenses				
14. Patient Incentives				
15. Reach Out and Read Expenses				
16. Fines and Penalties				
17. Miscellaneous Income				
18. Interest Income				
19. Other (Specify):				
20. Other (Specify):				
21. Other (Specify):				
22. Other (Specify):				
23. Other (Specify):				
24. Other (Specify):				
25. Other (Specify):				
26. Other (Specify):				
27. Other (Specify):				
28. Other (Specify):				
29. Other (Specify):				
30. Other (Specify):				
31. Total			0	

Example Only - Do not Use

NPI Number: _____
 Reporting _____
 Period Begin: 1/0/00 _____
 Reporting _____
 Period End: 1/0/00 _____

Type of Data: _____

ADMINISTRATION BREAKDOWN - Addendum 3

Explanation of Entry	Column	Amount
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31.		
32.		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		

Example Only - Do not Use

49.		
50.		
51.		
52.		
53.		
54.		
55.		
56.		
57.		
58.		
59.		
60.		
61.		
62.		
63.		
64.		
65.		
66.		
67.		
68.		
69.		
70.		
71.		
72.		
73.		
74.		
75.		
76.		
77.		
78.		
79.		
80.		
81.		
82.		
83.		
84.		
85.		
86.		
87.		
88.		
89.		
90.		
91.		
92.		
93.		
94.		
95.		
96.		
97.		
98.		
99.		
100.		
101. Total Administration		0
	Total Administration per W/S 1	0
	Check Figure Should be Zero	0

APPENDIX B

Examples of Other Required Forms

Documents included in this appendix are only for reference and are not to be submitted.

FQHC Name					
General Ledger Trial Balance with Crosswalk					
Date					
FQHC General Ledger			Worksheet 1		
Account Description	acct Balanc	Subtotals	Section	Column	Line #
Physician Salaries	\$ 10		A	1	1
Physician Fringe	\$ 10		A	2	1
6360 · Outside Spec.Care Contract	\$ 10		A	3	1
Physician Asst Salaries	\$ 10		A	1	3
Physician Asst Fringe	\$ 10		A	2	3
Med Asst Salaries	\$ 10		A	1	6
Med Asst Fringe	\$ 10		A	2	6
Nurse Salaries	\$ 10		A	1	7
Nurse Fringe	\$ 10		A	2	7
Dentist Salaries	\$ 10		A	1	9
Dentist Fringe	\$ 10				
7240.1 · CME Dental	\$ 10				
7250.1 · Training & Education Dental	\$ 10	\$ 30	A	2	9
6015.2 · Dental Supplies	\$ 10		A	4	9
Dental Hygienist Salaries	\$ 10		A	1	10
Dental Hygienist Fringe	\$ 10		A	2	10
6029 · Contracted Mental Health	\$ 10		A	3	15
6100 · Laboratory Expenses	\$ 10				
6115 · Laboratory Supplies	\$ 10	\$ 20	A	4	17
6240 · Radiology Overreads	\$ 10		A	3	18
6215 · X-Ray Equip & Supplies	\$ 10		A	4	18
6300 · Pharmacy-Clinic Use	\$ 10				
6301 · UMC Dental pharmacy	\$ 10				
6390 · Other Pharmacy	\$ 10				
6305 · Pharmacy contract	\$ 10				
6310 · 340B Pharmacy	\$ 10	\$ 50	A	4	19
Medical Records Salaries	\$ 10		A	1	25
Medical Records Fringe	\$ 10		A	2	25
6401 · Transcription	\$ 10				
6355 · Translation	\$ 10	\$ 20	A	3	29
6102 · Lab Expense- Dental	\$ 10		A	4	30
6045.1 · Dental Equip Rep & Maint	\$ 10				
6050.1 · Dental Equipment	\$ 10	\$ 20	A	4	31
6045 · Medical Equip Rep & Maint	\$ 10				
6050 · Medical Equipment	\$ 10	\$ 20	A	4	32
6060 · Medical Dues & Subscriptions	\$ 10				
6090 · Other Medical Expense	\$ 10	\$ 20	A	4	33
6015 · Medical Supplies	\$ 10		A	4	34
Dental Asst Salaries	\$ 10		A	1	35
Dental Asst Fringe	\$ 10		A	2	35
Eligibility Salaries	\$ 10		A	1	36
Eligibility Fringe	\$ 10		A	2	36
6140 · Outside Laboratory	\$ 10		B	3	45
Administrative Salaries	\$ 10		C	1	51
Administrative Fringe	\$ 10		C	2	51
6514 · Printing, Publications & Postage	\$ 10				
6621 · Facility Interest	\$ 10				
6560 · Dues & Subscriptions	\$ 10				
6560.1 · CCHN Dues & Subscriptions	\$ 10				
6580 · Board Expense	\$ 10				
6585 · Recruitment & Retention	\$ 10				
6590 · Other Administrative Expenses	\$ 10				
Healthy Living Leader Training	\$ 10	\$ 80	C	4	51
Financial Salaries	\$ 10		C	1	52
Financial Fringe	\$ 10		C	2	52

6575 - Accounting, Legal & Consulting	\$	10				
6575.3 - Audit	\$	10	\$	20	C	3 52
6572 - Community Outreach/Education	\$	10			C	4 53
6575.1 - Legal Expense	\$	10			C	3 54
Data Processing Salaries	\$	10			C	55
Data Processing Fringe	\$	10			C	2 55
6525.1 - IT Support	\$	10			C	3 55
6527 - Computer System Maintenance	\$	10			C	4 55
6629 - Janitorial	\$	10			C	3 56
6615 - Maintenance Supplies	\$	10			C	4 56
6645 - Repairs & Maintenance	\$	10			C	4 57
6400 - Medical Records	\$	10				
6515 - Office Supplies	\$	10				
6515.5 - Ink & toner	\$	10	\$	30	C	4 59
6535 - Insurance	\$	10				
6635 - Facility Insurance	\$	10	\$	20	C	4 60
6599 - Telephone	\$	10			C	4 61
6617 - Utilities	\$	10			C	4 62
8000 - Depreciation Expense	\$	10			C	4 64
6520 - Travel/Mileage	\$	10				
6520.5 - Travel-Dental	\$	10				
6521 - Meetings	\$	10	\$	30	C	4 67
6690.1 - Property Taxes	\$	10			C	4 70
6525 - Computer Expense	\$	10				
6526 - Computer Equipment & Supplies	\$	10				
6545 - Office Equipment	\$	10	\$	30	C	4 71
6511 - Bank Fees	\$	10				
6622 - Laundry	\$	10				
6690 - Other Facility	\$	10	\$	30	C	4 72
Total Expense per Audit	\$	840				

Sample FTE Report

FQHC Name
 FTE Report
 Date

<u>Department</u>	<u>FTE</u>
Physician	1.00
Physician Assistant	1.00
Nurse	1.00
Medical Assistant	1.00
Dentist	1.00
Hygienist	1.00
Dental Assistant	1.00
Mental Health	1.00
Case Manager	1.00
Eligibility	1.00
Management	1.00
Fiscal & Billing	1.00
IT	1.00
Facility	1.00
Support Staff	1.00
Other-Detail	1.00
Other-Detail	1.00
Other-Detail	1.00
Total	18.00

Sample Only. Do Not Use.

APPENDIX C

Pharmacy Overhead Allocation Form

FQHCs must submit a Pharmacy Overhead Allocation Form along with their cost report forms. The Pharmacy Overhead Allocation Form may be found [here](#).

FQHC Pharmacy Overhead Calculation Instructions

This form is designed to allocate FQHC overhead costs to the pharmacy for FQHC cost reporting purposes. The goal of the allocation is to exclude both direct pharmacy cost and pharmacy overhead cost from the FQHC encounter rate. The allocation of overhead to the pharmacy is based on the following methodology:

1. There are three different categories (or types) of overhead costs: costs not applicable to the pharmacy, costs directly attributable to the pharmacy, and costs shared between the pharmacy and other service lines or cost centers. Step 1 of the form assigns overhead costs to one of the three categories.
2. Category 1 costs, those not applicable to the pharmacy, are not included in the allocation to the pharmacy.
3. Category 2 costs, those directly attributable to the pharmacy, are reclassified from the overhead section to the non-reimbursable section of Worksheet 1 on the cost report. Step 2 of the form reclassifies the expense.
4. Category 3 costs, those shared by the pharmacy and other service lines or cost centers, are allocated to the pharmacy based on a statistic that is appropriate for the nature of expense. Step 3 of the form identifies the allocation statistics, assigns an appropriate statistic to each type of overhead expense, and then calculates the allocation of overhead to the pharmacy based on the statistic identified.

Important Notes

- A. All expense included in Worksheet 1 Section C, Overhead, must be assigned to a category in Step 1 of the form. Cost report adjustments to overhead expense reported in Section C should be included, as well.
- B. A single general ledger account may be classified in multiple categories, if the account contains expenses that meet the criteria of multiple categories. For example:

Account 600001, Administrative Wages, contains salary expense for the following individuals:

Job Title	Wages In Account 600001
Front Desk Receptionist	25,000
Pharmacy Clerk	27,000
Human Resources Officer	55,000
Account 600001 balance	107,000

The salary expense for the individuals included in account 600001 should be classified according to the relationship between the individual and the pharmacy. In this case:

Job Title	Category	Relationship to Pharmacy
Front Desk Receptionist	Category 1	Not applicable to pharmacy
Pharmacy Clerk	Category 2	Directly attributable to pharmacy
Human Resources Officer	Category 3	Shared between pharmacy and other service lines

- C. Overhead expense accounts of similar nature may be combined into a single entry if they fall within the same category (to reduce the number of entries required within the form).

APPENDIX D

FQHC Change-in-Scope Process

In order to comply with section 702(b) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106 – 554, the Colorado Department of Health Care Policy and Financing (Department) has developed a scope-of-service rate adjustment methodology for Federally Qualified Health Centers (FQHCs). This methodology will adjust the baseline Prospective Payment System (PPS) rate whenever an FQHC experiences a valid change in scope of service. For a description of a valid change in scope of service, please see 10 CCR 2505-10 8.700.6.D.5, which can be found on the Department’s website.

An FQHC must apply for a scope-of-service rate adjustment as soon as possible after a valid change in scope of service (i.e. in conjunction with the FQHC’s first cost report after the valid change in scope of service) in order for that change in scope of service to be on record with the Department, regardless of if that change in scope application will trigger the 3% threshold. For a scope-of-service rate adjustment to be considered, the change in scope of service must have existed for at least a full six (6) months. Only one scope-of-service rate adjustment will be calculated per year. However, more than one change in scope of service may be included in a single application.

All Scope-of-Service Rate Adjustments Applications must include the Application Form and Attestation Statement. The Application Form and Attestation Statement should be submitted with the FQHC’s cost report. The Department will use the data from the cost report before the change in the scope of services and the data from the most recent cost report to calculate the scope-of-service rate adjustment. If the Department’s calculated scope-of-service rate adjustment is not a 3% difference from the current Prospective Payment System Rate, the change(s) in the scope of service shall fail to trigger a scope-of-service rate adjustment. **The application and application instructions for a scope of service rate adjustment can be found on the Department’s external website, which may be found [here](#).**

Please read through the Scope-of-Service Rate Adjustment Instructions and complete the Scope-of-Service Rate Adjustment Application if your FQHC has experienced a qualifying change in the scope of services.

APPENDIX E

Definitions

Allowable costs: costs that are reasonable and associated with providing services that are defined in Colorado's Medicaid State Plan, in the FQHC's HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#). Allowable costs include those directly or indirectly tied to patient care, and those related to increasing access for the target patient population or informing them of available services.

Eligible Provider: providers who generate an encounter. Limited to: physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor, and behavioral health masters level candidates for licensure.

Encounter or Billable Visit: a one-on-one, face-to-face visit between an FQHC client and an Eligible Provider. Group sessions do not generate a billable encounter for any FQHC services.

Federally Qualified Health Center (FQHC): an entity which is a recipient of a grant under Section 330 of the Public Health Service Act.

Fee-for-Service: billing of Medicaid for covered services reimbursed at the standard Medicaid fee schedule, not at the FQHC's encounter rate. All costs of services reimbursed at the standard Medicaid fee schedule must be included in the cost report, but will be adjusted out. Only the services listed in the cost report instructions may be reimbursed at the standard Medicaid fee schedule.

Incident to: refers to services and supplies that are an integral, though incidental, part of the physician's professional service and are: commonly rendered without charge or included in the FQHC bill; commonly furnished in an outpatient clinic setting; furnished under the physician's direct supervision; and furnished by a member of the FQHC staff. Incident to services and supplies include: drugs and biologicals that are not usually self-administered; venipuncture; bandages, gauze, oxygen, and other supplies; or assistance by auxiliary personnel such as a nurse, medical assistant, or anyone acting under the supervision of the physician, per the [Medicare Benefit Policy Manual, Chapter 13](#), Section 110.

Unallowable costs: costs associated with providing services that are not included in Colorado's Medicaid State Plan, in the FQHC's HRSA-approved scope of project, or in the [Medicare Benefit Policy Manual, Chapter 13](#). Unallowable costs include costs associated with self-promotion with the intent of attracting patients who already have a health care home, advertising costs related to fundraising, and costs related to the staff performing those functions.