INDIAN HEALTH SERVICE

URBAN INDIAN HEALTH PROGRAMS

COMMON REPORTING REQUIREMENTS

INSTRUCTION MANUAL

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INDIAN HEALTH SERVICE

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PUBLIC REPORTING BURDEN FOR INFORMATION COLLECTION
OMB 0917-0007 - EXPIRATION DATE 00/00/00

Public reporting burden for this collection of information is estimated to average from 30 minutes to 135 minutes per response depending on the form, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. *An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.* Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 12300 Twinbrook Parkway, Suite 450, Rockville, MD 20852-1006, ATTN: PRA (0917-0007). Do not return the completed form to this address.

BURDEN ESTIMATE - OMB 0917-0007	
Data Collection Instrument	Average Burden Hour per Response*
Face Sheet	0.50 (30 mins)
Table 1	2.00 (120 mins)
Table 2	0.75 (45 mins)
Table 3	2.25 (135 mins)
Table 4	0.50 (30 mins)
Table 5	2.00 (120 mins)
Table 6	2.00 (120 mins)
Table 7	1.00 (60 mins)
Table 8	1.25 (75 mins)

*For ease of understanding, burden hours are also provided in actual minutes.

WHEN REPORTS ARE DUE

A. The FACE SHEET must be included each time any table is submitted. The reporting period for the FACE SHEET should match the reporting period for each attached table submitted. Tables with different reporting periods should be submitted under separate FACE SHEETS.

B. All Tables are submitted annually for the twelve month fiscal year (October 1-September 30).

C. New programs that become operational after the beginning of the fiscal year must report for the portion of the fiscal year for which they have been operational.

D. All Tables of the UCRR are due by November 10 following the September 30 end of the fiscal year. Two copies of all Tables of the UCRR are to be submitted annually.

WHO SHOULD SUBMIT REPORTS

A. The tables for the Urban Indian Health Common Reporting Requirements (UCRR) must be submitted by all organizations directly receiving Federal funds under Title V of The Indian Health Care Improvement Act, P.L. 94-437 and its Amendments.

B. Organizations must report on their entire health activity even though it may be supported only in part by the Indian Health Service (IHS) grant(s) or contract(s).

C. IHS funded organizations with WIC programs should integrate the utilization, staffing, costs, revenues and expenditures associated with these services into what they report. However, WIC monies received for food and associated food distribution cost should not be reported since the program is merely acting as a conduit for the funds.

DEFINITION OF GENERAL TERMS

PROGRAM:
For the purpose of these reporting requirements, this term is used to describe the approved activities performed as a result of contracts, grants or health personnel received from Indian Health Service programs. These activities include at least the provision of a specified set of health services to a defined target population and may be carried out in more than one site.

HEALTH SERVICE SITE:
For the purpose of these reporting requirements, this term is used to identify locations or sites where a program provides IHS supported health services to patients on a regularly scheduled basis. A site could be a free-standing clinic facility, physician's office, mobile unit or clinic within a non-health related facility (e.g., a clinic located in a church).

INSTRUCTIONS FOR SUBMITTING REPORTS

GENERAL:

1. Submit copies of the reports as follows:
   a. Two (2) copies to the appropriate Program Officer or IHS Area Urban Coordinator.

2. All questions should be directed to the Program Officer or IHS Area Urban Coordinator.

3. Record the appropriate reporting period and enter the corresponding year in space 3) on the FACE SHEET.

4. Any table completed either in a manner inconsistent with the definitions or instructions must have an attached explanation. However, it may not be possible to incorporate data into the processing system when non-standard definitions are used, and it is recommended that the program contact the Program Officer or IHS Area Urban Coordinator.

5. When submitting revisions of tables or tables omitted from a previous submission:
   a. Include only those tables that are being revised or initially submitted for this reporting period; do not include tables which have already been submitted and require no revision;
   b. If the entire table is not being revised, circle the specific data cells that are being revised to bring attention to them.

6. **Do not submit any blank tables.**
   a. If the entire table is not applicable, the table must be submitted with the note "not applicable" indicated on the table.
   b. If any part of a table is applicable, only the cells containing activity should be completed. If the table is applicable, but no activity to be reported on it, the table must be submitted with the note "zero activity" indicated on the table. An applicable report which is not submitted constitutes noncompliance.

USE OF THE INSTRUCTION MANUAL

FORMAT

Each of the UCRR tables is explained in a separate subsection within the manual. Each subsection is organized in a format that includes the following major headings:

INSTRUCTIONS: This provides information on how to record the required data on each table. In some instances, both general and specific instructions are provided. The applicable portion of the table instructions is indicated by column letter (COLUMN) and line number (LINE).

DEFINITIONS: All terms applicable to the table are listed within this section. Terms are explained as they appear or are relevant to the table.

SUMMARY OF TABLES

The following is a brief summary of each table:

TABLE 1: Number of Program Users By Age and Gender
Table 1 shows the number of unduplicated program users, within each age and gender category, who received services provided by the program at least once during the past year. This table can be utilized in evaluating service area needs by illustrating the extent to which services are being provided to specific age and gender groups.

TABLE 2: Number of Program Users By Service Group, Indian and Non-lndian
Table 2 reflects the number of Medical, Dental, Allied Health, Substance Abuse and Community Service program users by service group among Indians and non-lndians. By combining the data from this table with the encounter data on Table 3, the average number of encounters per user can be calculated.

TABLE 3: Staff and Encounters by Service Group and Type of Provider
Table 3 provides a summary of all program personnel allocated to the service group in which each performs their duties and responsibilities. In addition, Table 3 shows the number of encounters during the period for each service group.

TABLE 4: Hospital Inpatient Encounters and Type of Admission
Table 4 reports the number of hospital admissions made by staff providers and the number of hospital encounters by staff providers by type of admission, i.e., pediatric, internal medicine, obstetric and other. This table can be used to complement the data from Table 3 in evaluating provider productivity.

TABLE 5: Selected Clinical Services
Table 5 records program performance on six selected clinical indicators: immunization levels; family planning counseling for adolescents; pap smear follow-up; hypertension follow-up; anemia screening; and diabetes follow-up.

TABLE 6: Costs by Service Group
Table 6 shows the costs of operation during the reporting period, based on accrual methods of accounting. These costs are allocated to the service groups specified in Table 3 and are categorized as personnel, other costs (including consultant, contract, facility, equipment, supplies, depreciation and insurance), and donated goods and services. In addition, clinic overhead functional costs, i.e., administration and facility costs are distributed to the various health care service groups in order to arrive at total costs of the health care functions.

TABLE 7: Accounts Receivable, Charges and Collections by Source of Funds
Table 7 shows the total beginning and ending accounts receivable, charges and collections for reimbursable services provided by a program during the reporting period. It also shows the amount of adjustments by type; e.g., disallowances and reductions, sliding payment scale adjustments, bad debt write offs, etc. Information from this table can be used to compare charges to the costs shown on Table 6 and to calculate the average collection period.

TABLE 8: Summary of Fiscal Year Income and Expenses
Table 8 shows income and expenses for the fiscal year. It includes all income from Federal grants and contracts, income from other sources, such as state and local funds, accrued reimbursements from patients and third parties for services rendered, and capital and non-capital expenditures. This table can be used to examine a program's sources and uses of funds and to assist in budget preparation.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

FACE SHEET

1) Program: _____

Location: _____

Additional Site(s): _____

_____

2) Contract No: _____

3) Reporting Period: ☐ Revision

October 19_____ **through September 19 ____**

or

_____ 19____ **through _____ 19 ____**

4) Program Address: _____

_____

_____

5) Name and Telephone Number of Person Preparing Report:

_____

_____

6) Director:

Signature & Date: _____

OMB No. 0917-0007 Expiration Date: 00/00/00

INSTRUCTIONS FOR COMPLETING THE FACE SHEET

1. PROGRAM, LOCATION, AND ADDITIONAL SITE(S): The name, main location (city and state), and any associated site(s) must be included on the FACE SHEET in order to assure proper accreditation of the submission.

2. CONTRACT NUMBER: The IHS contract number(s) under which the reported services were performed.

3. REPORTING PERIOD: The Reporting Period MUST cover the Federal Government fiscal year from October 1 through September 30. Enter the terminal digits of the years for this report or the specific period covered by this report. Place an "X" in the Revision box if this report replaces a prior report.

4. PROGRAM ADDRESS: Enter the address of the program as shown in grant or contract applications and other correspondence with the IHS.

5. NAME AND TELEPHONE NUMBER OF PERSON PREPARING REPORT: Enter the name and business telephone number of the staff person with primary responsibility for preparing the UCRR. Do not give the name of a data processing contractor (contractor employee) involved in preparing the UCRR.

6. DIRECTOR: The Director should print and sign their name on the original copy of the UCRR and date the report. This signature constitutes formal endorsement of the content of the report.

FREQUENCY: Each time a table is submitted initially for a reporting period, or as a revision, it should be accompanied by a FACE SHEET.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 1: NUMBER OF PROGRAM USERS BY AGE AND GENDER

Program Name: _____

	AGE & GENDER	PROGRAM USERS	
		Indian (a)	Non-Indian (b)
	Female		
1)	< 1		
2)	1 - 4		
3)	5 - 9		
4)	10 - 12		
5)	13 - 14		
6)	15 - 19		
7)	20 - 24		
8)	25 - 34		
9)	35 - 44		
10)	45 - 54		
11)	55 - 64		
12)	65 - 74		
13)	75-84		
14)	> 84		
15)	**Subtotal**		
	Male		
16)	< 1		
17)	1 - 4		
18)	5 - 9		
19)	10 - 12		
20)	13 - 14		
21)	15 - 19		
22)	20 - 24		
23)	25 - 34		
24)	35 - 44		
25)	45 - 54		
26)	55 - 64		
27)	65 - 74		
28)	75-84		
29)	> 84		
30)	**Subtotal**		
31)	**Total**		

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TABLE 1: NUMBER OF PROGRAM USERS BY AGE AND GENDER

INSTRUCTIONS

SPECIFIC:

1. Indian Female unduplicated program users are reported by age on LINES 1 through 14, COLUMN (a).

2. Non-Indian Female unduplicated program users are reported by age on LINES 1 through 14, COLUMN (b).

3. Indian Female unduplicated program users are subtotaled on LINE 15, COLUMN (a).

4. Non-Indian Female unduplicated program users are subtotaled on LINE 15, COLUMN (b).

5. Indian Male unduplicated program users are reported by age on LINES 16 through 29, COLUMN (a).

6. Non-Indian Male unduplicated program users are reported by age on LINES 16 through 29, COLUMN (b).

7. Indian Male unduplicated program users are subtotaled on LINE 30, COLUMN (a).

8. Non-Indian Male unduplicated program users are subtotaled on LINE 30, COLUMN (b).

9. Indian unduplicated program users are totaled on LINE 31, COLUMN (a).

10. Non-Indian unduplicated program users are totaled on LINE 31, COLUMN (b).

11. For the purposes of this report, use the user's age as of June 30 of the reporting period.

12. Unduplicated program users, not encounters, are reported on this table. An unduplicated program user is someone who has had at least one encounter during the last year.

DEFINITIONS

PROGRAM USER: An individual who has had one or more encounters during the past year. An individual can be counted only once as each of the following types of program users.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 2: NUMBER OF PROGRAM USERS BY SERVICE GROUP, INDIAN AND NON-INDIAN

Program Name: _____

SERVICE GROUP	PROGRAM USERS	
	Indian (a)	Non-Indian (b)
1) Medical		
2) Obstetrics/Gynecology/Prenatal		
3) Ancillary Services		
4) Dental		
5) Health Education		
6) Nutrition Services		
7) Behavioral Services		
8) Other Allied Health Services		
9) Community Health Services		
10) Enabling Services		

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TABLE 2: NUMBER OF PROGRAM USERS BY TYPE OF SERVICE GROUP, INDIAN AND NON-INDIAN

INSTRUCTIONS

GENERAL:

Programs which serve only some of the population groups should only complete the cells which are applicable. Line 8, "Other Allied Health Services" is available for those programs which have services that are not listed in other Service Groups on TABLE 2. For example, perhaps a program has audiology services. Users of the Audiology service would be entered in the Other Allied Health Services category.

The unduplicated count of Program Users, not encounters, are recorded in COLUMNS (a) and (b). All encounters are recorded on TABLE 3.

SPECIFIC:

1. Record on LINE 1, COLUMN (a) those Medical program users who are Indian.
2. Record on LINE 1, COLUMN (b) those Medical program users who are Non-lndian.
3. Record on LINE 2, COLUMN (a) those Obstetrics/Gynecology/Prenatal program users who are Indian.
4. Record on LINE 2, COLUMN (b) those Obstetrics/Gynecology/Prenatal program users who are Non-lndian.
5. Record on LINE 3, COLUMN (a) those Ancillary Services program users who are Indian.
6. Record on LINE 3, COLUMN (b) those Ancillary Services program users who are Non-lndian.
7. Record on LINE 4, COLUMN (a) those Dental program users who are Indian.
8. Record on LINE 4, COLUMN (b) those Dental program users who are Non-lndian.
9. Record on LINE 5, COLUMN (a) those Health Education program users who are Indian.
10. Record on LINE 5, COLUMN (b) those Health Education program users who are Non-lndian.
11. Record on LINE 6, COLUMN (a) those Nutrition Services program users who are Indian.
12. Record on LINE 6, COLUMN (b) those Nutrition Svcs. program users who are Non-lndian.
13. Record on LINE 7, COLUMN (a) those Behavioral Services program users who are Indian.
14. Record on LINE 7, COLUMN (b) those Behavioral Services program users who are Non-lndian.
15. Record on LINE 8, COLUMN (a) those Other Allied Health Services program users who are Indian.
16. Record on LINE 8, COLUMN (b) those Other Allied Health Services program users who are Non-lndian.
17. Record on LINE 9, COLUMN (a) those Community Health Services program users who are Indian.
18. Record on LINE 9, COLUMN (b) those Community Health Services program users who are Non-lndian.
19. Record on LINE 10, COLUMN (a) the Enabling Services program users who are lndian.
20. Record on LINE 10, COLUMN (b) the Enabling Services program users who are Non-lndian.

TABLE 2: NUMBER OF PROGRAM USERS BY TYPE OF SERVICE GROUP, INDIAN AND NON-INDIAN

DEFINITIONS

PROGRAM USER: An individual who has had one or more encounters during the past year. An individual can be counted only once as each of the following types of program users.

Medical Program User: An individual who has had one or more medical encounters, i.e., encounters with a medical provider, during the reporting period.

Obstetrics/Gynecology/Prenatal Program User: An individual who has had one or more Obstetric, Gynecological, or Prenatal Care encounters, i.e., encounters with a primary care provider or nurse, during the reporting period.

Ancillary Services Program User: An individual who has had one or more laboratory, imaging, or pharmacy service encounters during the reporting period.

Dental Program User: An individual who has had one or more dental encounters, i.e., encounters with a dental provider, during the reporting period.

Health Education Program User: An individual who has had one or more health education encounters, i.e., encounters with a health education provider, during the reporting period.

Nutrition Services Program User: An individual who has had one or more nutrition encounters, i.e., encounters with a nutrition provider, during the reporting period.

Behavioral Services Program User: An individual who has had one or more mental health, substance abuse, or social services encounters, i.e., encounters with a mental health, substance abuse, or social services provider, during the reporting period.

Other Allied Health Services Program User: An individual who has had one or more encounters with an Allied Health Services provider, during the reporting period.

Community Health Services Program User: An individual who has had one or more community health services encounters, i.e., encounters with a community health services provider, during the reporting period.

Enabling Services Program User: An individual who has had one or more encounters with an Enabling Services provider, during the reporting period.

NOTE: Exhibit A includes a list of typical provider types for each service group.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 3: STAFF AND ENCOUNTERS BY SERVICE GROUP AND TYPE OF PROVIDER

Program Name: _____

SERVICE GROUP & PROVIDER TYPE	ON-SITE SERVICES		NO. OF REFERRALS	
	STAFF - Full-Time Equivs.	Number of Encounters	Paid	Not Paid For
1) MEDICAL				
a) Physicians				
b) Mid-Level Practitioners				
c) Nurses (Medical)				
d) Medical Support				
2) OBSTETRICS/GYN./PRENATAL				
a) Physicians				
b) Mid-Level Practitioners				
c) Nurses (Medical)				
d) Medical Support				
3) ANCILLARY SERVICES			NUMBER OF SERVICES	
a) Laboratory (Medical)			Procedures:	
b) Imaging (Medical)			Films:	
c) Pharmacy (Medical & Dental)			Fills & Refills:	
4) DENTAL				
a) Dentists				
b) Dental Hygienists/Oral Therapists				
c) Dental Support				
5) HEALTH EDUCATION				
a) Health Education Providers				
b) Health Education Support				
6) NUTRITION SERVICES				
a) Nutrition Providers				
b) Nutrition Support				
7) BEHAVIORAL SERVICES				
a) Mental Health Counselors				
b) Substance Abuse Counselors				
c) Social Services Providers				
d) Behavioral Services Support				
8) OTHER ALLIED HEALTH SVCS.				
a) Other Allied Health Svcs. Providers				
b) Other Allied Health Svcs. Support				
c) Optical Service Providers				
d) Traditional Indian Medicine				
9) COMMUNITY HEALTH SVCS.				
a) Community Services Providers				
b) Community Services Support				
10) ENABLING SERVICES				
a) Case Managers (of referrals)				
b) Eligibility Support				
c) Employment/Housing Support				
d) Child Care (during visits)				
e) Transportation (for visits)				
f) Interpreters				
g) Other Enabling Services				
11) PROGRAM OVERHEAD				
a) Patient Records				
b) Administration				
c) Facility				
12) TOTAL				

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TABLE 3: STAFF AND ENCOUNTERS BY SERVICE GROUP AND TYPE OF PROVIDER

INSTRUCTIONS

SPECIFIC:

1. The program's name should be entered at the top of the table.

2. ON-SITE SERVICES: STAFF – Full Time Equivalents

a. Allocation of Personnel Time to Service Group(s):

A direct staff person's time should be split among one or more service groups when the time devoted to each area is 10 percent or more. If a staff person normally spends more than 90 percent of his/her time in one service group, then 100 percent of his/her time may be reported to that service group. If a staff person normally spends less that 90 percent of his/her time in a major service group, then the remainder of the time should be allocated to all appropriate service groups that account for the significant portions: i.e., 10 percent or more, of the staff person's time.

Care should be taken to insure that 100 percent of each staff person's time is accounted for in this table.

i. The time reported for physician, mid-level practitioners, and dental providers should not be split among service groups with the following exception:

Health care staff who devote at least 10 percent of their time to overall program administration (for example, Medical Director, Dental Director or Nursing Supervisor) should have this portion of their time shown in Administration (Line 11b). The allocation of their time should be in accordance with the following guidelines:

a) Medical, dental and allied health functional service groups should reflect only time spent on the following departmental activities: providing clinical services; managing personnel and other resources; and performing clinical quality assurance activities in these departments.

b) The clinic overhead administration service group should only reflect time spent in overall program management and administrative activities. For example, these may include preparation of a funding application, budget/planning meetings of department heads, participation in public meetings and contract or labor negotiations.

TABLE 3 – INSTRUCTIONS (Continued)

ii. Nurses should divide their time only when significant portions of time are spent functioning in different categories, such as a laboratory technician, patient educator or counselor, medical nurse, nursing supervisor or administrator. (See i. above for differentiating a nursing supervisor's time.) Nurses should not divide their time between the "Nurses (Medical)" and "Medical Support" service group.

iii. When a staff person's time is allocated to more than one service group, his/her salary and fringe benefits must be allocated to the same service groups on TABLE 6.

iv. Small programs which do not keep individual personnel time records by service groups may estimate staff full time equivalents for each service group in which a significant portion of an individual's time is spent, using a methodology which is acceptable to the Program Officer or Urban Area Coordinator.

b. Calculation of Full Time Equivalents:

Staff full time equivalents are computed on an individual basis by dividing the total number of hours in the reporting period for which a person was compensated by the total number of hours in the reporting period considered by the program to be full-time. The total number of hours for which an individual was compensated includes the number of hours a person was present for work and reimbursed for his/her time, as well as paid leave time (vacation, sick leave, continuing education, trips, etc.). The number of hours the program organization considers full-time must be at least 1600 hours per year. If not, each of its employees must be reported as less than full-time. An individual staff member cannot be reported as more than 1.0 staff full-time equivalent despite any overtime compensation which may appear on TABLE 6. For example, an employee working 835 hours during the year, where full-time is considered to be 1,700 hours would have a 0.5 (835÷1,700= 0.49; rounded to 0.5) FTE.

NOTE: All calculations for staff full-time equivalent should be aggregated according to the applicable service groups. Round all figures to no more than one decimal place (tenths).

3. ON-SITE SERVICES: Number of Encounters

Enter all on-site staff encounters as on-site services. On-site staff encounters include those generated on-site by paid staff, by non-paid volunteers, and by those providers who are billed directly for their services (including fee for services, capitation and retainer arrangements). Include only the encounters generated by providers whose time is accounted for as part of the STAFF – Full-Time Equivalents. Include on-site contract encounters as part of on-site services. On-site contract encounters are those performed on-site by providers who are billed for their services on a fee-for-service, capitation, or retainer basis. Their time is accounted for as part of the on-site staff, as FTE's. Include physician and mid-level encounters that are also reported on TABLE 4.

TABLE 3 – INSTRUCTIONS (Continued)

4. NUMBER OF REFERRALS: Paid

Enter the count for all paid referrals (encounters). Paid referrals are those performed off-site by providers who are billed for their services on a fee-for-service, capitation, or retainer basis. Their time is not accounted for as on-site staff FTE's.

5. NUMBER OF REFERRALS: Not Paid For

Enter the count for all referrals (encounters) not paid for. Referrals not paid for are those performed off-site by providers do not bill for their services. Their time is not accounted for as on-site staff FTE's.

Whether referrals are paid or not paid for, the program must receive some record that the service was actually performed; that is, the referral was completed, and that one or more encounters were generated.

TOTAL: Enter the total of all on-site staff full-time equivalents, the total of all on-site encounters, the total of off-site paid referrals, and the total of off-site referrals, not paid for on LINE 12.

NOTE: The Staff and Encounters reported in TABLE 3 must align with the costs reported in TABLE 6. This means there cannot be a Service Group tallying encounters (TABLE 3) without an associated cost. Similarly, there cannot be a cost (TABLE 6) without any encounters.

DEFINITIONS

STAFF BY SERVICE GROUP: Is a breakdown of personnel according to the functions they perform. An individual may appear in more than one service group if significant portions of his or her work time are distributed across the various service groups.

STAFF FULL-TIME EQUIVALENTS (FTE'S): Is a numerical expression of the number of hours for which full-time and part-time staff are compensated in terms of the program's definition of full-time. With the exception of NHSC assignees, personnel must be compensated for at least 1600 hours per year in order to be considered full-time. One staff person who worked full-time for an entire recording period would be 1.0 full time equivalent.

TABLE 3 – DEFINITIONS (Continued)

STAFF: Individuals who work for a program on a regularly scheduled time basis under any of the following compensation arrangements:

- salaried full-time;
- salaried part-time;
- contract/retainer/capitation/fee-for-service/block time basis;
- National Health Service Corps assignees; or
- donated services.

Scheduled time requires that the individual is committed to a pre-assigned number of work hours which are devoted to program activities.

REFERRALS: Services delivered by individuals who do not work for a program and who deliver these services off-site on an irregular basis.

PAID REFERRALS: The count of the number of encounters by program clients with service providers who are reimbursed on a fee-for-service basis, capitation or retainer arrangement.

UNPAID REFERRALS: The count of the number of encounters by program clients with service providers who are not reimbursed for the services delivered. The value of unpaid volunteers donated time should be formally documented in accounting records and documented in TABLE 6.

PROVIDER: The individual who assumes primary responsibility for assessing the patient and exercises independent judgement as to the services rendered to the patient during an encounter. The provider who is in charge of the encounter in which two or more providers are present and participate is the one credited with the encounter.

Medical Services Provider: Physicians (primary care physicians, psychiatrist, other medical and surgical specialists), mid-level practitioners (physician's assistants and nurse practitioners), and nurses who provide independent, direct, face-to-face medical services to patients during an encounter.

Obstetrics/Gynecological/Prenatal Services Provider: Physicians, obstetricians, and gynecologists (primary care physicians and other medical specialists), mid-level practitioners (physician's assistants, nurse practitioners, nurse-midwives), and nurses who provide independent, direct, face-to-face medical services to Obstetrics/Gynecological/Prenatal patients during an encounter.

Dental Services Provider: Dentists, dental hygienists, and oral therapists who provide independent, direct, face-to-face dental services to patients during an encounter.

Health Education Services Provider: Health education providers who provide independent, direct, face-to-face health education services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

TABLE 3 – DEFINITIONS (Continued)

Nutrition Services Provider: Nutrition services providers who provide independent, direct, face-to-face nutrition and dietetic counseling services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

Behavioral Services Provider: Behavioral services providers who provide independent, direct, face-to-face mental health, substance abuse, and/or social services counseling services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

Other Allied Health Services Provider: Optometry, audiology, AIDs counseling and other allied health providers who provide independent, direct, face-to-face services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

Community Health Services Provider: Community health workers and community outreach staff who provide independent, direct, face-to-face services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

Enabling Services Provider: Health services workers and community outreach staff who provide independent, direct, face-to-face services to patients during an encounter (these do not include Medical, Obstetrics/Gynecological/Prenatal, Dental, or Community Services providers).

NOTE: Exhibit A includes a list of typical provider types for each service group.

NON-PROVIDER: Personnel who facilitate the provision of health services during an encounter but who themselves do not assess patients' conditions or exercise independent judgment in the provision of patient care. Non-provider applies to all ancillary services, support services and clinic overhead personnel, as well as medical support, dental support, other allied health support, and enabling services personnel.

The distinction between provider personnel and support personnel may be based on the functional organization of each program and job descriptions of staff at each program.

ENCOUNTER: A face-to-face contact between a user and a provider of health care services who exercises independent judgment in the provision of health services to the individual patient. For a health service to be defined as an encounter, the provision of the health service must be recorded in the patient's record. The criteria for encounters are given below:

- The provider must be acting independently and no assisting another provider.
- The patient record does not have to be a full and complete health record in order to meet the encounter criterion if a patient receives only one, or minimal, services and is not likely to return to the health center. However, the services rendered must be documented.

TABLE 3 – DEFINITIONS (Continued)

- A patient may have more than one encounter during one visit to the health center. Multiple encounters are recorded for distinct services by different service groups.
- A provider may be credited with no more than one encounter with a given patient during that patient's visit, regardless of the type or number of services provided.

An encounter may take place in the health center or at any other location in which program-supported activities are carried out.
- When a provider renders services to several patients simultaneously, the provider can be credited with an encounter for each person if the provision of services is noted in each person's health record.

The encounter criteria are not met in the following circumstances:
- When a provider participates in a community meeting or group session which is not designed to provide health services.
- When the only health services provided is part of a large scale effort, such as a mass immunization, screening, or community-wide service (e.g., a health fair).
- When a home health aide does not render any health service, but provides homemaker services (this may instead be included as a community service encounter).

MEDICAL ENCOUNTER: An encounter between a medical provider and a user during which medical services are provided for the prevention, diagnosis, treatment and rehabilitation of illness or injury. Included in this category are physician encounters, mid-level practitioner encounters, and nurse encounters.

OBSTETRICS/GYNECOLOCY/PRENATAL ENCOUNTER: An encounter between a medical provider and a user during which medical services are provided for the diagnosis, treatment, and rehabilitation of obstetric, gynecological or prenatal condition or illness. Included in this category are physician encounters, mid-level practitioner encounters, and nurse encounters.

DENTAL ENCOUNTER: An encounter between a dental provider and a user for the purpose of prevention, assessment or treatment of a dental problem, including restoration.

NOTE: A dental hygienist or oral therapist is credited with an encounter only when (s)he provides service independently, not jointly with a dentist.

HEALTH EDUCATION ENCOUNTER: An encounter between a qualified health education provider and a user.

NUTRITION SERVICES ENCOUNTER: An encounter between a qualified nutrition services provider and a user.

TABLE 3 – DEFINITIONS (Continued)

BEHAVIORAL SERVICES ENCOUNTER: An encounter between a qualified behavioral services provider and a user.

OTHER ALLIED HEALTH SERVICES ENCOUNTER: An encounter, within a recognized discipline, between an allied health provider and a user, for the purposes of prevention, education, assessment, or treatment of an allied health problem.

COMMUNITY HEALTH SERVICES ENCOUNTER: An encounter between a community health service provider and a user during which health outreach, advocacy, or assistance are provided for increasing patient access to health care services.

ENABLING SERVICES ENCOUNTER: An encounter between a health service provider and a user during which case management, transportation, education, or supporting services are provided for increasing patient access to health care services.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 4: HOSPITAL INPATIENT ENCOUNTERS AND TYPE OF ADMISSION

Program Name: _____

TYPE OF ADMISSION	PATIENT ADMISSIONS BY PROGRAM STAFF	HOSPITAL INPATIENT ENCOUNTERS BY PROGRAM STAFF
	(a)	(b)
1) Pediatrics		
2) Internal Medicine		
3) Obstetrics/Gynecology		
Other (Specify):		
4) _____		
5) _____		
6) _____		
7) TOTAL		

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TABLE 4: HOSPITAL INPATIENT ENCOUNTERS AND TYPE OF ADMISSION

INSTRUCTIONS

SPECIFIC:

1. The total number of patient admissions by program staff should be entered on the line of the appropriate clinical service in COLUMN (a).

2. All "Other" patient admissions by program staff should be specified by entering the name(s) of the clinical service(s) (or abbreviation) in the space provided in the left column of LINE 4 and the number of admissions by program staff for each specified "Other" service recorded in COLUMN (a).

3. The total number of patient admissions by program staff, LINES 1 through 6, COLUMN (a) should be recorded in LINE 7, COLUMN (a).

4. The total number of inpatient encounters by program staff should be entered on the line of the appropriate clinical service in COLUMN (b).

5. All "Other" inpatient encounters by program staff should be specified by entering the name(s) of the clinical services(s) (or abbreviation) in the space provided in the left column of LINE 4 and the number of inpatient encounters by program staff for each specified "Other" service recorded in COLUMN (b).

6. The total number of inpatient encounters by program staff, LINES 1 through 6, COLUMN (b) should be recorded in LINE 7, COLUMN (b).

7. The total number of hospital inpatient encounters shown in this table should also appear as part of the medical encounters shown in TABLE 3, COLUMN (b).

TABLE 4: HOSPITAL INPATIENT ENCOUNTERS AND TYPE OF ADMISSION

DEFINITIONS

PATIENT ADMISSIONS BY PROGRAM STAFF: The number of hospital admissions by the following program staff members:

- all salaried physicians and mid-level practitioners; and
- all donated or contracted physicians and mid-level practitioners.

NOTE: To be recorded on TABLE 4, patients must be attended by the providers designated above in their capacity as program staff. Non-staff inpatient encounters and admissions should not be recorded on TABLE 4.

HOSPITAL INPATIENT ENCOUNTERS: Encounters by the medical staff member(s) who assumes the medical management responsibility of the patient during hospitalization. Also includes consultation visits by physicians and mid-level practitioners. Hospital visits by the program's nursing, allied health, substance abuse and community service staff are not included on TABLE 4, but are included in COLUMN (b) on TABLE 3.

NOTE: Only one (1) hospital encounter per patient, per site (hospital) per day can be reported for medical staff providers regardless of the number of times they visit a hospitalized patient during the day.

TYPE OF INPATIENT SERVICES: Patients should be classified according to the inpatient clinical service or hospital department to which they are admitted.

Pediatrics: The clinical service concerned with the diagnosis and nonsurgical treatment of children.

Internal Medicine: The clinical service concerned with the diagnosis and nonsurgical treatment of adults.

Obstetrics: The clinical service concerned with the care and treatment of women during pregnancy, childbirth and the postpartum period; does not include gynecology.

Other: All clinical services other than Pediatrics. Internal Medicine or Obstetrics.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 5: SELECTED CLINICAL SERVICES

Program Name: _____

CLINICAL USER CATEGORY	RECORDS SAMPLED	RECORDS IN COMPLIANCE
	(a)	(b)
1) Immunization (24-27 months)		
2) Immunization (6 years old)		
3) Immunization (Adult)		
4) Family Planning Counseling (under 20 years)		
5) Pap Smear Follow-Up		
6) Hypertension Follow-Up (10 years and older)		
7) Anemia Screening (24-27 months)		
8) Diabetes Follow-Up		

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TABLE 5: SELECTED CLINICAL SERVICES

INSTRUCTIONS

SPECIFIC:

1. Immunization, LINES 1, 2 and 3:

   Records Sampled. COLUMN (a): If the program has an immunization tracking system, at least 20 records of active patients in each age category should be selected. If the program has not established an immunization tracking system, the program should select a statistically valid sample of records.

   Records in Compliance. COLUMN (b): The number of records sampled which have documentation of all recommended immunizations, as specified in the Public Health Service/American Academy of Pediatrics Schedule or the Immunization Practices Advisory Committee of the U.S. Public Health Service.

2. Adolescent Family Planning Counseling, LINE 4:

   Records Sampled. COLUMN (a): The program should select at least 20 records of active patients under 20 years of age who have had a family planing encounter with a medical provider for the purpose of receiving a family planning method. If family planning services are not offered by the program's staff enter 0 on LINE 3, COLUMNS (a) and (b).

   Records in Compliance. COLUMN (b): The number of records sampled which have documentation that counseling was provided prior to, or at the time of, receiving any family planning method.

3. Pap Smear Follow-up, LINE 5:

   Records Sampled. COLUMN (a): In order to allow six weeks for follow-up of Class 111, IV and V pap smears showing dysplasia or any form of carcinoma, programs must review the records of all women which show Class III, IV and V pap smear results (dysplasia or any form of carcinoma) for tests performed six weeks prior to the beginning of the reporting period and six weeks prior to the end of the reporting period.

   Records in Compliance. COLUMN (b): The number of records of patients counted in COLUMN (a) which have documentation of follow-up and further diagnostic study by a gynecologist within six weeks of the date the results of the abnormal pap smear were received. Follow-up and further diagnostic study may be provided by either a program staff gynecologist or through referral out of the program. All programs must report on this indicator even if they do not pay for follow-up referral. Records which show documented attempts at contacting the patient without success or patient refusal of follow-up care can be counted as in compliance, but this should be a rare occurrence.

TABLE 5 – INSTRUCTIONS (Continued)

4. Hypertension Follow-up, LINE 6:

   Records Sampled. COLUMN (a): The program should select at least 20 records of active patients, aged 10 or older, who have been diagnosed as hypertensive according to the program's criteria for hypertension.

   Records in Compliance. COLUMN (b): The number of records sampled which have documentation of adherence to the program's treatment plan for hypertension, or the treatment plan developed for the individual patient. It is the responsibility of each program to develop its own hypertension health care plan and criteria for adherence. Adherence is determined by ascertaining whether the visits for blood pressure follow-up have occurred as outlined in the treatment plan; and if appointments were missed, whether efforts to re-engage the patient in therapy were made and documented. Further, the record should show either progress toward the blood pressure goal or reasons why progress has not been made.

5. Anemia Screening, LINE 7:

   Records Sampled. COLUMN (a): The program should select at least 20 records of active patients, aged 24-27 months.
   Records in Compliance. COLUMN (b): The number of records sampled which have documentation of a hematocrit or hemoglobin measurement since the time of registration.

6. Diabetes Follow-up, LINE 8:

   Records Sampled. COLUMN (a): The program should select at least 20 records of active patients, age 10 and older, who have been diagnosed according to the program's criteria for diabetes.

   Records in Compliance. COLUMN (b): The number of records sampled which have documentation of adherence to the program's treatment plan for diabetes, or the treatment plan developed for the individual patient. It is the responsibility of each program to develop its own diabetes health care plan and criteria for adherence. Adherence is determined by ascertaining whether the visits for diabetes treatment follow-up have occurred as outlined in the treatment plan; and if appointments were missed, whether efforts to re-engage the patient in therapy were made and documented. Further, the record should show either progress toward the diabetes treatment goal or reasons why progress has not been made.

TABLE 5: SELECTED CLINICAL SERVICES

DEFINITIONS

RECORDS SAMPLED: Records to be audited are selected from the program's file of active patients. Active patients are defined as those who have had at least one medical encounter 24 months prior to the audit. Records for immunization and anemia screening audits should be drawn from the records of the appropriate universe of active patient groups for the particular indicator. Records for pap smear follow-up should be drawn from those results of tests performed during the reporting period which show Class III, IV or V dysplasia or any form of carcinoma. Records for adolescent family planning counseling, hypertension, and diabetes follow-up audit can be drawn from the records of those patients who had an encounter for these purposes during each 6 month reporting period (either October through March or April through September). These patients may be identified through daily log, appointment roster, computer printouts, diagnostic registers, or other listing of users during the reporting period.

At least 20 records of active patients whose health records could be examined for a particular clinical service must be sampled for each reported clinical indicator. If there are fewer than 20 records of active patients for any indicator, then the charts of all active users whose health records could be examined for a particular clinical service must be included. Programs may use a universal count, rather than a sampling of records, to report any indicator.

A single health record may be audited for several applicable clinical services. For example, the record of a two year-old may be examined for documentation of immunization and hematocrit/hemoglobin measurement. this record counts as one of 20 required records to be sampled for each of these clinical service.

Programs with multiple service delivery sites should develop clinical quality assurance mechanisms by which records from each site are sampled periodically for the reported clinical services. These programs have the option of sampling records from each site for each submission of this table, or rotating record sampling among sites, provided that records from each site are sampled at least annually.

RECORDS IN COMPLIANCE: Records sampled which have documentation of all required services provided at the appropriate time, as specified for each clinical service, are in compliance.

SAMPLING PROCEDURES

THE GENERAL APPROACH TO RANDOM SAMPLING

Random sampling is a way to select a sample so that the sample results reflect, within an error range known in advance of the sampling, the results that would be obtained by tabulating the universe of data. If sampling is to be used in completing TABLE 5 of the UCRR. a random sampling method must be employed.

The general approach to random sampling is as follows:

1. Define exactly what you are trying to obtain (for example, the number of Medical Users aged 6 years old).

2. Identify the source from which you will extract the data (for example, patient records, encounter forms, patient registration index, daily logs, etc.).

3. Determine how large the sample size will be (for example, how many patient records will be reviewed).

4. Determine the sampling plan por example, how the pulling of records will occur and which records will be pulled).

5. Collect and analyze the data (for example, determine what portion of the sample turned out to be Medical Users aged 6 years old).

6. Complete the data (cell(s).

The next section describes an acceptable methodology for completing TABLE 5 by random sampling. The methodology requires that a minimum of 20 records be examined in order to yield a sample that provides an acceptably accurate representation of the universal count being studied. The basic procedure requires that records be pulled in a random fashion until 20 records containing relevant data (for example, a 6 year old medical user during the calendar year) are selected.

HOW TO SAMPLE TO COMPLETE TABLE 5

If patient records are filed alphabetically (numerically):

1. Using a random number table, pick a set of 20 two digit numbers that have values between "01" and "26".* Note that the same number may be included several times in the list.
   * If records are filed numerically, pick a set of 20 numbers that have values within the range of numbers used by the program to identify patient records.

2. Make a list of the numbers selected in Step 1 above and match them to letters in the alphabet. (Not necessary for a numerical records system).

TABLE 5 – SAMPLING PROCEDURES (Continued)

3. Use the top letter (number) on the list as a guide to which letter section (or number) of the record file from which you pull a sample record. NOTE: If you are repeating this step use the first letter not crossed off.

4. Select the first record in the alphabetical section.** If this section (letter) has appeared before on the list generated in Step 2, then select the first record following the last record pulled from that section.
   ** With a numerical system, if the record to be pulled is not on file, then pull the next record in the file.

5. Examine the record to see if there was a Medical Encounter during the fiscal year.

6. If the record does not indicate an encounter during the year, replace it and pull the next record in the file. Keep a count of the total number of records that had to be pulled in order to get 20 records with relevant encounters.

7. When a record has been pulled which does indicate an encounter (or encounters) during the calendar year, mark the outside with an "I" and set aside.***
   *** It is suggested that some "flag" or "outguide" be placed in the file at the point where this record was taken. This will allow staff to readily determine where to begin the next search in that section letter) of the file, if the same letter appears again on the pull list generated in Step 3.

8. Cross off the letter on the list generated in Step 2 which was used to pull the record. The next letter on the list should then be considered the "top" letter on the list.

9. Repeat Steps 3 through 8 until 20 records with activity during the year have been pulled and set aside.

10. Examine the 20 records and fill out sample copies of TABLE 5 noting the appropriate cell(s). One record can be used for completing multiple cells if applicable.

TABLE 6: COSTS BY SERVICE GROUP

Program Name:

SERVICE GROUP	TOTAL PERSONNEL SALARY COST from WORKSHEET A, COLUMN (h) (a)	OTHER COSTS from WORKSHEET B, COLUMN (e) (b)	VALUE OF DONATED MATERIAL AND SERVICE from WORKSHEET B, COLUMN (f) (c)	TOTAL COSTS BEFORE DISTRIBUTION (d)	TOTAL AFTER DISTRIBUTION OF FACILITY COSTS from WORKSHEET C, COLUMN (e) (e)	TOTAL AFTER DISTRIBUTION OF OVERHEAD from WORKSHEET C, COLUMN (h) (f)
1a) Medical						
1b) Inpatient						
2) OB/GYN/Prenatal						
3a) Laboratory (Medical)						
3b) Imaging (Medical)						
3c) Pharmacy (Med.& Dental)						
4) Dental (incl. Lab & Imag.)						
5) Health Education						
6) Nutrition Services						
7) Behavioral Services						
8) Other Allied Health Svcs.						
9) Community Health Svcs.						
10) Enabling Services						
11) Patient Records						
12) Fringe Benefits						
13) Administration						
14) Facilities						
15) TOTAL						

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TABLE 6: COSTS BY SERVICE GROUP

INSTRUCTIONS

GENERAL:

1. All costs associated with the services and activities included in the program's approved application for IHS funding, including those associated with delegate agency operations, should be reported on this table.

2. The home health activities should be included in TABLE 6 according to the type of service(s) performed.

3. Amounts should be rounded off to the nearest dollar.

4. Negative symbols (parentheses, brackets, minus signs) should not be used.

5. This is an accrual basis table. Costs reported on TABLE 6 represent the amounts consumed during the reporting period, regardless of when payments are made. See the adjustments necessary to convert costs from cash to accrual basis in Exhibit B.

6. Amounts to be entered in this table are period specific, as of the end of each fiscal year.

7. Reporting of personnel costs by service group TABLE 6 should be consistent with the allocation of staff full-time equivalents on TABLE 3. No service group should have encounters in TABLE 3 without staff reported in TABLE 3 for the same service group AND no service group should have staff reported in TABLE 3 without salary costs (or donated services) reported in TABLE 6 for the same service group.

SPECIFIC:

1. Programs which maintain their financial records on a cash basis must convert the financial data to the accrual basis according to the steps outlined in Exhibit B.

2. Programs which maintain their financial records according to the budget line items must convert the financial data to the TABLE 6 service groups.

3. In order to assign costs to the appropriate service group and cost type, individual invoices and other available documentation may need to be reviewed.

Completion of TABLE 6:

1. Personnel Salary Cost, COLUMN (a): Includes wage and salary costs, the distributed costs of patient records and fringe benefits, and administration and facilities.

Programs which keep patient records cost separately should include the patient records personnel costs from WORKSHEET A, COLUMN (c) or from the program's own cost allocation records for each service group.

Programs which have assigned or allocated fringe benefits to the cost centers throughout the reporting period need only to combine the salary and fringe benefits amounts (after conversion to the accrual basis) and enter the amount on the line corresponding to that cost center.

Programs that maintain all fringe benefits costs together, rather than by service group, should allocate the fringe benefit costs to the service groups using WORKSHEET A, COLUMNS (e) through (g).

Enter total personnel costs (salaries and fringe benefits) for each service group on TABLE 6, COLUMN (a), LINES 1 through 14 from the data in the program's records or from WORKSHEET A, COLUMN (h).

Total COLUMN (a), LINES 1 through 14 and enter the total on LINE 15, COLUMN (a).

2. Other, COLUMN (b): Includes all costs (except salaries and fringe benefits) as classified by service group after adjustments have been made to record actual consumption rather than expenditures. This includes depreciation of fixed assets that were purchased directly by the program.

   Programs which keep patient records costs separately should include the patient records other costs from WORKSHEET A, COLUMN (d) or from the program's own cost allocation records for each service group.

   Enter total other costs for each service group in COLUMN (b), LINES 1 through 14. Total COLUMN (b), LINES 1 through 14 and enter the total on LINE 15, COLUMN (b).

3. Value of Donated Materials and Services, COLUMN (c): Includes all costs necessary and prudent to the operation of the activities and services of the program which are not paid for directly by the program.

   The estimated fair market value assigned to each donation at the time of the donation is the basis for calculating the cost for the reporting period. The donated cost classification includes:

   a. The imputed reasonable cost of National Health Service Corps assignees, not the amount reimbursed;

   b. The Fair Market Value of all personnel who are donated and are not considered employees; and,

TABLE 6 – INSTRUCTIONS (Continued)

c. Depreciation costs on all donated equipment and facilities, and the amount consumed during the reporting period of any other donated materials or supplies.

Enter the total value of donated materials and services in COLUMN (c) on LINE 15.

4. Total before Distribution, COLUMN (d): Total LINE 15 of COLUMNS (a), (b) and (c) and enter the total in COLUMN (d).

5. Refer to WORKSHEET C, COLUMN (h), for calculation of the amounts to be entered in COLUMN (e), LINE 1b. Column (e), LINE 1b of TABLE 6 must be filled in.

6. Complete all totals and verify all consistency checks for TABLE 6 and WORKSHEET C.

FOR PROGRAMS THAT HAVE MULTIPLE HEALTH SERVICE SITES AND/OR DELEGATES:

Include all costs associated with health care delivery, including the clinic overhead costs of both the program and the delegate.

FOR SERVICES CONTRACTED OUT TO OTHER PROVIDERS ON A SERVICE UNIT OR PER CAPITA BASIS:

1. Examples:

- An Indian health program which contracts with all its delegates on a negotiated unit cost basis.

- An Indian health program which contracts with several group practices or private practitioners on a negotiated, prepaid capitation or unit cost basis.

- Programs which are funded by an Area Office on a capitated basis.

2. Only complete the open cells of TABLE 6.

a. COLUMN (b), LINES 1 through 10: Programs must break down the negotiated unit rate or capitation rate by cost center in order to accurately reflect the components of the rate in reporting TABLE 6. In other words, the program must report the cost components that comprise the health care portion of the negotiated rate on LINES 1 through 10, COLUMN (b).
b. LINES 13 and 14, COLUMN (b): Programs must show on these lines their own clinic overhead administration and facility costs, plus all the costs associated with the administration and facility components of the negotiated unit rate or capitation rate.

TABLE 6 – INSTRUCTIONS (Continued)

c. LINE 15, COLUMN (b), Total.

d. LINES 1 through 15, COLUMNS (e) and (f): Programs must show in the open cells of these columns the total costs after the allocation of clinic overhead functions including facility and administration.

CONSISTENCY CHECKS:

1. TABLE 6: COLUMN (a) matches WORKSHEET A: COLUMN (h)

2. TABLE 6: COLUMN (b) matches WORKSHEET B: COLUMN (e)

3. TABLE 6: COLUMN (c) LINE 15 equals WORKSHEET B: COLUMN (f) LINE 15

4. TABLE 6: COLUMN (d) LINE 15 is the sum of TABLE 6: COLUMN (a) LINE 15 plus COLUMN (b) LINE 15 plus COLUMN (c) LINE 15

5. TABLE 6: COLUMN (e) LINE 15 equals WORKSHEET C: COLUMN (e) LINE 13

6. TABLE 6: COLUMN (f) matches WORKSHEET C: COLUMN (h)

DEFINITIONS

COST: Cost represents that portion of prior, current, and future expenditures which are actually consumed or can reasonably and systematically be allocated to the current period. This includes the value of all goods and services consumed or allocated to the reporting period for which no expenditure is required (e.g., donated goods and services, NHSC personnel, volunteer services, depreciation).

SERVICES GROUPS: A classification system for costs incurred in the provision of health services, allocated by type of service.

HEALTH CARE SERVICE GROUP COSTS: All costs, including the cost of donated goods and services, incurred in delivering health services. Health care service costs are generated in the following functional categories:

Medical Costs: Costs incurred in providing medical services either on-site or off-site for the prevention, diagnosis, treatment and rehabilitation of illness or injury. Includes costs of providing medical services which are incidental to or an integral part of the services provided by a physician or other medical provider. This service group also includes the costs of inpatient care by medical staff providers, nursing services (including home health services), and all

TABLE 6 – DEFINITIONS (Continued)

routine and specialized medical services provided by the program. Costs include medical malpractice insurance and may include patient records costs if easily assigned to the medical cost center.

Inpatient Costs: Costs incurred for inpatient or extended care facility services for which the program assumes the responsibility for payment. This includes non-staff providers, room and board, and ancillary services while the patient is in the hospital as an inpatient. Excluded from this category are costs associated with inpatient services provided by program staff providers and support personnel whose staff time and costs are reported under the medical service group. Hospital charges incurred for the diagnosis and treatment of outpatients are included in the other appropriate health care service groups, not the inpatient service group.

OB/GYN/Prenatal Costs: Costs incurred in providing independent, direct, face-to-face medical services to Obstetrics/Gynecological/Prenatal patients during an OB/GYN or prenatal visit.

Laboratory (Medical) Costs: Costs of outpatient laboratory services, with the exception of dental laboratory services, either performed on-site or off-site. These costs include payments to outside laboratories for services provided to program patients.

Imaging (Medical) Costs: Costs of providing outpatient x-ray diagnostic and therapeutic services, except dental x-rays, performed either on-site or off-site. These costs include payments to out-aide x-ray s for services provided to program patients.

Pharmacy Costs: Costs of operating a pharmacy and/or dispensary within the program or payments to commercial pharmacies for prescriptions filled for program patients for all health services, including dental services, for which the clinic is billed. The costs of pharmaceutical dispensed by a provider other than a pharmacist are also included in this service group.

Dental Costs: Costs incurred in providing dental services for the purpose of prevention, assessment or treatment of a dental problem, including dental laboratory, imaging, and prosthetics, whether the services are performed on-site or off-site. Costs include dental malpractice insurance and may include patient records costs if easily assigned to the dental service group.

Health Education Costs: Costs incurred in providing a defined program of health education services either performed on-site or off-site for the purpose of health education and disease prevention, including family planning education and counseling. Costs include any share of malpractice insurance, respective allied health support costs, and may include patient records costs if easily assigned to the health education service group.

Nutrition Costs: Costs incurred in providing a defined of nutrition services for the purpose of prevention, assessment, or counseling of a nutritional problem, whether the services are performed on-site or off-site. Costs include any share of malpractice insurance, respective

allied health support costs, and may include patient records costs if easily assigned to the nutrition service group.

Behavioral Health Costs: Costs incurred in providing a defined of behavioral health services either on-site or off-site for the prevention, assessment, counseling, treatment, or rehabilitation of a psychosocial problem including substance abuse. Costs include any share of malpractice insurance, respective allied health support costs, and may include patient records costs if easily assigned to the mental health service group.

Other Allied Health Services Costs: Costs incurred in providing other defined programs of allied health services, either on-site or off-site. These may include audiologist, optometric costs, podiatrist, speech pathologist, physical therapist or respiratory therapist services. Costs include any share of malpractice insurance, respective allied health service support costs and medical records costs if easily assigned to this service group.

Community Health Service Costs: Costs incurred in the provision of activities which inform prospective patients of the availability of program services and maintain continuity of patient care. This category includes outreach and/or recruitment of prospective patients, assisting patients in obtaining services from other health and social service agencies and follow-up work with patients who are not using services appropriately; e.g. who have missed appointments. Costs may include medical records costs if easily assigned to this service group.

Enabling Services Costs: Costs incurred in the provision of activities that assist patients in accessing program services and maintain continuity of patient care. This category includes assisting patients in obtaining services from other health and social service agencies and follow-up work with patients who are not using services appropriately; e.g. who have missed appointments. This may also include costs incurred in providing transportation for patients including the following: the cost of leasing vehicles; the costs of ambulance service; bus and cab fares; other forms of patient transportation paid for by the program; and personnel costs associated with transportation services. Costs may include medical records costs if easily assigned to this service group.

CLINIC OVERHEAD FUNCTIONAL COSTS: All costs, including the value of donated materials and services, necessary to administer or operate the overall health care program. These costs are later distributed among the health care service groups in order to obtain cost figures that measure the total amount of resources required to perform each of the health care functions. The clinic overhead functions are comprised of the following:

Administrative Costs: Costs associated with the administrative and general management activities of the Program. For programs with pre-paid activities, costs include marketing costs related to the development and implementation of s designed to enroll and retain members in the prepaid plan.

TABLE 6 – DEFINITIONS (Continued)

Facility Costs: Costs associated with using and maintaining the physical plant of onsite facilities including housekeeping and maintenance, security, utilities, rental and depreciation.

NOTE: Patient records costs, including personnel and other costs associated with maintaining the program's health records, should be allocated to the appropriate service group(s) according to the methodology for WORKSHEET A or the program's own methodology.

COST CATEGORIES: A categorization system for costs incurred in the provision of health services, consolidated into the following categories:

Salaried Personnel: Those costs incurred by the program for compensation of its employees for their services during the reporting period; i.e., gross salaries and wages, including annual and sick leave, holiday pay, overtime, bonuses and the cost of fringe benefits.

Fringe benefits include the employer's share of employee hospitalization, medical and dental insurance Worker's Compensation, employee group insurance, Social Security taxes (FICA), unemployment compensation, annuity, and pensions. Fringe benefits do not include membership dues, subscriptions, continuing education and other similar costs. Fringe benefit expenses are either assigned directly or allocated to the functional cost center to which the employee's salary or wages are assigned.

Other: All costs, other than salaries and fringe benefits, which were incurred by the program. Included in this category are the costs of:

- consultant and contract services;
- supplies consumed during the period;
- travel and training;
- depreciation of fixed assets including facilities, leasehold improvements and equipment;
- insurance, interest and taxes (other than payroll-related taxes which are included in personnel costs as a part of fringe benefits);
- postage, freight, telephone, answering service;
- and rent and utilities.

Value of Donated Materials and Services: All costs which are necessary and prudent to the operation of the program and which are not paid for directly by the program. This category includes the estimated fair market value of donated personnel, supplies, services, space rental and depreciation for the use of donated facilities and equipment. The estimated fair market value is calculated according to the cost that would be required to obtain similar services, supplies, equipment or facilities within the immediate area at the time of the donation. The fair market value is only recognized when the intent of the donating parties is explicit and when the services, supplies, etc., are both prudent and necessary to the program's operation. The full value of National Health Service Corps (NHSC) assignees(s), not the amount reimbursed, is also included in this category. UHSC furnished equipment, including dental operatories, is capitalized at the amount shown on the NHSC Equipment Inventory Document, and the appropriate depreciation expenses (based on the life of the equipment) is shown in this category for the reporting period.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

WORKSHEET A: DISTRIBUTION OF PATIENT RECORDS AND FRINGE BENEFITS COSTS

Program Name: _____

SERVICE GROUP	DISTRIBUTION OF PATIENT RECORDS COSTS				DISTRIBUTION OF FRINGE BENEFITS COSTS			
	Number of Encounters	Percent (%) of Total Encounters	Patient Records Salaried Costs Distribution	Personnel Salary Costs	Personnel Salary Costs With Patient Records Salaries	Percent (%) of Total Salaries	Finge Benefits Distribution	Total Sal Personnel
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
1a) Medical								
1b) Inpatient								
2) OB/GYN/Prenatal								
3a) Laboratory (Medical)								
3b) Imaging (Medical)								
3c) Pharmacy (Med.& Dental)								
4) Dental (incl. Lab & Imag.)								
5) Health Education								
6) Nutrition Services								
7) Behavioral Services								
8) Other Allied Health Svcs.								
9) Community Health Svcs.								
10) Enabling Services								
11) Patient Records			( )					
12) Fringe Benefits							( )	
13) Administration								
14) Facilities								
15) TOTAL		100%	$0			100%	$0	

WORKSHEET A: DISTRIBUTION OF PATIENT RECORDS AND FRINGE BENEFITS COSTS

APPLICABILITY: Programs may allocate patient records salary costs and fringe benefits costs in accordance with the methodology demonstrated on the WORKSHEET A to obtain the amounts for COLUMN (a) on TABLE 6. WORKSHEET A does not have to be used and it **should not be submitted.**

Those programs with accounting systems that can routinely distribute patient records costs to health care service groups may not need to use WORKSHEET A and may complete COLUMN (a) of TABLE 6 with the amounts generated by their own methodologies. The program must retain a copy of WORKSHEET A and any other work papers and records used to do the allocation.

INSTRUCTIONS

GENERAL:

1. Dollar amounts should be rounded to the nearest dollar.

2. Percentage figures may be rounded to whole numbers provided the column total equals 100 percent.

3. Negative symbols are pre-printed on WORKSHEET A as parenthesis where subtractions are necessary.

4. If used, WORKSHEET A should be retained by the program and not submitted with the other tables.

SPECIFIC:

1. Distribution of Patient Records Costs:
   If the program has already assigned patient records personnel across the health care service groups on TABLE 3, the program should use the same methodology for allocating the rest of the patient records costs in order to maintain consistency in cost allocation methodology.

   If patient records costs have not been assigned to health care service groups, complete the following steps:

   Transfer Personnel Salary Costs to WORKSHEET A

   a. Enter the total personnel salary costs attributable to patient records from the program's books into WORKSHEET A, COLUMN (c), LINE 11 as a negative number. Note that COLUMN (e) LINE 15 TOTAL is greater than COLUMN (d) LINE 15 TOTAL.

   b. Enter the total personnel salary costs attributable to service groups from the program's books into WORKSHEET A, COLUMN (d), LINES 1 through 10.

WORKSHEET A – INSTRUCTIONS (Continued)

c. Enter the total personnel salary costs attributable to administration and to facilities from the program's books into WORKSHEET A, COLUMN (d), LINES 13 and 14, respectively.

d. Enter the total personnel salary costs attributable to fringe benefits from the program's books into WORKSHEET A, COLUMN (g), LINE 12 as a negative number.

Compute distribution of patient records salaried costs

a. Total medical encounters from TABLE 3, COLUMN (b), LINES 1a) through 1d) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 1.

   Total OB/GYN/Prenatal encounters from TABLE 3, COLUMN (b), LINES 2a) through 2d) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 2.

   Total dental encounters from TABLE 3, COLUMN (b), LINES 4a) through 4c) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 4.

   Total health education encounters from TABLE 3, COLUMN (b), LINES 5a) through 5b) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 5.

   Total nutrition services encounters from TABLE 3, COLUMN (b), LINES 6a) through 6b) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 6.

   Total behavioral services encounters from TABLE 3, COLUMN (b), LINES 7a) through 7d) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 7.

   Total other allied health services encounters from TABLE 3, COLUMN (b), LINES 8a) through 8d) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 8.

   Total community health services encounters from TABLE 3, COLUMN (b), LINES 9a) through 9b) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 9.

   Total enabling services encounters from TABLE 3, COLUMN (b), LINES 10a) through 10g) and transfer the total onto WORKSHEET A, COLUMN (a), LINE 10.

b. Total COLUMN (a), the number of encounters on WORKSHEET A, LINE 1 through LINE 10 and transfer the total onto WORKSHEET A, COLUMN (a), LINE 15.

c. In COLUMN (b), divide each of the numbers on LINES 1, 2, 4, 5, 6, 7, 8, 9, and 10 COLUMN (a) by the total on LINE 15, COLUMN (a) and enter the percentage obtained on the corresponding line in COLUMN (b), percentage of total encounters. Round the figures to whole numbers as necessary to ensure that the total of percentages in COLUMN (b) equals 100 percent.

d. Multiply each percentage from COLUMN (b) by the patient records salaried personnel costs on LINE 11, COLUMN (c) and enter the result on the corresponding line of COLUMN (c) as positive numbers.

   Total COLUMN (c) and check that the total equals "0" on LINE 15. Note that LINE 11 is a negative number.

Compute personnel salary costs, including distribution of patient records salaried costs

a. Sum the medical patient records salaried costs distribution, COLUMN (c) LINE 1 with the medical personnel salary costs, COLUMN (d) LINE 1 and enter the total in COLUMN (e) LINE 1, medical personnel salary costs with patient records salaries.

b. Perform similar computations for LINE 2 through LINE 10, computing the totals to be entered in COLUMN (e), personnel salary costs with patient records salaries.

c. Transfer the personnel salary costs attributable to administration and facilities from COLUMN (d), LINE 13 and LINE 14 to COLUMN (e) LINE 13 and LINE 14.

2. Distribution of Fringe Benefits Costs

If fringe benefits have been allocated to the actual salaries or wages within each service group, this distribution will not be necessary. The program need only transfer its total personnel costs (including fringe benefits) by service group, to TABLE 6, COLUMN (a).

Compute distribution of fringe benefits

If fringe benefits have **not** been distributed, complete the following steps:

a. Verify that personnel salary costs as classified by service group are listed in COLUMN (e) on WORKSHEET A. Total all amounts in COLUMN (e) and enter the total on LINE 15, COLUMN (e).

b. Divide each of the numbers in COLUMN (e) by the total on LINE 15 and enter the percentage obtained on the corresponding line in COLUMN (f). Round the figures to whole numbers as necessary to ensure that the total of the percentages in COLUMN (f) equals 100 percent.

WORKSHEET A – INSTRUCTIONS (Continued)

c. Confirm that the total fringe benefits cost is entered on LINE 12, COLUMN (g) as a negative number. Multiply each percentage from COLUMN (f) by the total fringe benefits costs on LINE 12, COLUMN (g) and enter the results on the corresponding line of COLUMN (g) as positive numbers.

d. Total COLUMN (g) and check that the total equals "0" on LINE 15. Note that LINE 12 is a negative number.

e. For each line, except LINE 12, add the amounts in COLUMN (e) to the amounts in COLUMN (g) and enter the total in COLUMN (h). Total COLUMN (h) and transfer COLUMN (h) in its entirety to WORKSHEET B, COLUMN (a).

   Copy the entries in COLUMN (h) to the corresponding lines in WORKSHEET B, COLUMN (a).

   Copy the entries in COLUMN (h) to the corresponding lines in TABLE 6, COLUMN (a).

CONSISTENCY CHECKS:

1. WORKSHEET A: COLUMN (a) LINE 15 TOTAL Encounters equals TABLE 3: LINE 12 TOTAL Encounters

2. WORKSHEET A: COLUMN (c) LINE 11 positive value plus COLUMN (d) LINE 15 equals COLUMN (e) LINE 15

3. WORKSHEET A: COLUMN (e) LINE 15 plus COLUMN (g) LINE 12 positive value equals COLUMN (h) LINE 15

DEFINITIONS

DISTRIBUTION OF PATIENT RECORDS COSTS, WORKSHEET A, COLUMNS (a), (b), (c) and (d): This section of WORKSHEET A is designed to assist programs in the allocation of patient records salaried personnel to service groups. The percentage of total encounters attributed to each of these cost centers applied to the patient records cost categories is used as the basis for this allocation.

DISTRIBUTION OF FRINGE BENEFITS COSTS, WORKSHEET A, COLUMNS (e), (f), (g) and (h): This section of WORKSHEET A is designed to assist programs in the allocation of fringe benefits on an equitable basis to the salaries with which they are associated. The basis of allocation used is the fringe benefit rate applied to total salaries by service group.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

WORKSHEET B: DISTRIBUTION OF OTHER COSTS

Program Name: _____

SERVICE GROUP	DISTRIBUTION OF PATIENT RECORDS COSTS			Total Salaried Personnel Costs	Other Costs With Patient Records Other Costs	Value of Donated Materials & Services	Total Costs B Distribution of I and Administ
	Percent (%) of Total Encounters	Patient Records Other Costs Distribution	Other Costs				
	(a)	(b)	(c)	(d)	(e)	(f)	(g)
1a) Medical							
1b) Inpatient							
2) OB/GYN/Prenatal							
3a) Laboratory (Medical)							
3b) Imaging (Medical)							
3c) Pharmacy (Med&Dent)							
4) Dental (w/Lab&Imag)							
5) Health Education							
6) Nutrition Services							
7) Behavioral Services							
8) Other Allied Hlth Svcs.							
9) Community Hlth Svcs.							
10) Enabling Services							
11) Patient Records		( )					
12) Fringe Benefits							
13) Administration							
14) Facilities							
15) TOTAL	100%	$0					

WORKSHEET B: DISTRIBUTION OF OTHER COSTS ACROSS SERVICE GROUPS

APPLICABILITY: Programs may allocate patient records costs in accordance with the methodology demonstrated on the WORKSHEET B to obtain the amounts for COLUMN (a) and COLUMN (b) on TABLE 6. WORKSHEET B does not have to be used and it **should not be submitted.**

Those programs with accounting systems that can routinely distribute patient records costs to health care service groups may not need to use WORKSHEET A and may complete COLUMN (a) and COLUMN (b) of TABLE 6 with the amounts generated by their own methodologies. The program must retain a copy of WORKSHEET B and any other work papers and records used to do the allocation.

INSTRUCTIONS

GENERAL:

1. Dollar amounts should be rounded to the nearest dollar.

2. Percentage figures may be rounded to whole numbers provided the column total equals 100 percent.

3. Negative symbols are pre-printed on WORKSHEET B as parenthesis where subtractions are necessary.

4. If used, WORKSHEET B should be retained by the program and not submitted with the other tables.

SPECIFIC:

1. Compilation of Total Costs Before Distribution of Facility and Administration:

   If the program has already assigned patient records personnel across the health care service groups on TABLE 3, the program should use the same methodology for allocating the rest of the patient records costs in order to maintain consistency in cost allocation methodology.

   If patient records costs have not been assigned to health care service groups, complete the following steps:

   Transfer Other Costs to WORKSHEET B

   a. Enter the other costs attributable to service groups from the program's books into WORKSHEET B, COLUMN (c), LINES 1 through 10.

   b. Enter the other costs attributable to patient records from the program's books into WORKSHEET B, COLUMN (b), LINE 11 as a negative number.

WORKSHEET B – INSTRUCTIONS (Continued)

c. Enter the other costs attributable to administration and to facilities from the program's books into WORKSHEET B, COLUMN (c), LINES 13 and 14, respectively.

d. Copy the percent of total encounters from WORKSHEET A, COLUMN (b) to WORKSHEET B, COLUMN (a)

Compute other costs, including distribution of patient records other costs

a. Multiply each percentage from COLUMN (a) by the patient records other costs on LINE 11, COLUMN (b) and enter the result on the corresponding line of COLUMN (b) as positive numbers.

Total COLUMN (b) and check that the total equals "0" on LINE 15. Note that LINE 11 is a negative number.

b. Sum the medical patient records other costs distribution, COLUMN (b) LINE 1 with the medical other costs, COLUMN (c) LINE 1 and enter the total in COLUMN (e) LINE 1, medical other costs with patient records other costs.

c. Perform similar computations for LINE 2 through LINE 10, computing the totals to be entered in COLUMN (e), other costs with patient records other costs.

d. Copy the total other costs attributable to administration and facilities from COLUMN (c) LINES 13 and 14, into COLUMN (e) LINE 13 and COLUMN (b) LINE 14, respectively.

Compute Total Costs Before Distribution of Facility and Administration

a. Confirm that Total Salaried Personnel Costs WORKSHEET A, COLUMN (h) has been copied to WORKSHEET B, COLUMN (d).

b. Sum other costs COLUMN (e), LINE 1 through LINE 14, and enter the total on LINE 15.

Copy the other costs with patient records other costs in COLUMN (e) to the corresponding lines in TABLE 6, COLUMN (b).

c. Enter the value of donated services and materials attributable to each Service Group from the program's books onto COLUMN (f), LINE 1 through LINE 10. Enter the value of donated services and materials attributable to administration and facilities on COLUMN (f) LINE 13 and COLUMN (f) LINE 14, respectively.

Sum COLUMN (f), LINE 1 through LINE 14, and enter the total on LINE 15.

Copy the total in COLUMN (f), LINE 15 to the total in TABLE 6, COLUMN (c), LINE 15.

WORKSHEET B – INSTRUCTIONS (Continued)

d. Sum the medical total personnel salary costs, COLUMN (d) LINE 1, plus the medical other costs, COLUMN (e) LINE 1, with the value of donated medical services and materials, COLUMN (f) LINE 1 and enter the total in COLUMN (g) LINE 1, medical total costs before distribution of facility and administration.

e. Perform similar computations for LINE 2 through LINE 10, computing the totals to be entered in COLUMN (g), total costs before distribution of facility and administration. Also perform the computation for LINE 13 and LINE 14, entering the totals in COLUMN (d), total costs before distribution of facility and administration.

f. Sum the total salaried personnel costs, COLUMN (d) LINE 15, plus the total other costs, COLUMN (e) LINE 15, with the total value of donated medical services and materials, COLUMN (f) LINE 15, and enter the total in COLUMN (g) LINE 15, total costs before distribution of facility and administration.

   Copy the total in COLUMN (g), LINE 15 to the total in TABLE 6, COLUMN (d), LINE 15.

g. Transfer the total costs before distribution of facility and administration from COLUMN (g) to WORKSHEET C, COLUMN (a).

CONSISTENCY CHECKS:

1. WORKSHEET B: COLUMN (d) LINE 15 equals WORKSHEET A: COLUMN (h) LINE 15

2. WORKSHEET B: COLUMN (b) LINE 11 positive value plus COLUMN (c) LINE 15 equals COLUMN (c) LINE 15

3. WORKSHEET B: COLUMN (d) LINE 15 plus COLUMN (e) LINE 15 plus COLUMN (f) LINE 15 equals COLUMN (g) LINE 15

DEFINITIONS

DISTRIBUTION OF PATIENT RECORDS COSTS, WORKSHEET B, COLUMNS (a), (b), and (c): This section of WORKSHEET B is designed to assist programs in the allocation of patient records other costs to service groups. The percentage of total encounters attributed to each of these service groups applied to the patient records cost categories is used as the basis for this allocation.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

WORKSHEET C: DISTRIBUTION OF FACILITY AND ADMINISTRATION COSTS

Program Name: _____

SERVICE GROUP		DISTRIBUTION OF FACILITY COSTS				DISTRIBUTION OF ADMINISTRATION COSTS		
	Total Costs Before Distribution of Facility and Administration (a)	Square Feet of Space Used (b)	Space Percent (%) of Footage (c)	Facility Costs Distribution (d)	Total Costs After Distribution of Facility (e)	Percent (%) of Health Care Cost of Subtotal (16) (f)	Administration Costs Distribution (g)	Tot Di Ad
1a) Medical								
1b) Inpatient								
2) OB/GYN/Prenatal								
3a) Laboratory (Medical)								
3b) Imaging (Medical)								
3c) Pharmacy (Med&Dent)								
4) Dental (w/Lab&Imag)								
5) Health Education								
6) Nutrition Services								
7) Behavioral Services								
8) Other Allied Hlth Svcs.								
9) Community Hlth Svcs.								
10) Enabling Services								
11) Patient Records								
12) Fringe Benefits								
13) Administration							( )	
14) Facilities				( )				
15) TOTAL			100%	$0		100%	$0	
						<= (16) Health Care Cost Subtotal		

WORKSHEET C: DISTRIBUTION OF FACILITY AND CLINIC OVERHEAD COSTS ACROSS HEALTH CARE SERVICE GROUPS

APPLICABILITY: Programs must allocate costs, at a minimum, in accordance with the methodology demonstrated on the WORKSHEET C to obtain the amounts for COLUMNS (e) and (f) on TABLE 6. WORKSHEET C itself does not have to be used, and it **should not be submitted**.

Those programs with accounting systems that routinely distribute clinic overhead costs across health care service groups using a multiple step-down methodology which is more sophisticated than the one used in the WORKSHEET C may complete COLUMNS (e) and (f) on TABLE 6 with the amounts generated by their allocation methodologies.

The program must retain a copy of WORKSHEET C and any other work papers and records used to do the allocation.

INSTRUCTIONS

GENERAL:

1. Dollar amounts should be rounded to the nearest dollar.

2. Round figures to whole numbers as necessary to ensure that the total percentages in COLUMNS (c) and (f) equal 100 percent.

3. Negative symbols are pre-printed on WORKSHEET C as parenthesis where subtractions are necessary.

4. If used, WORKSHEET C should be retained by the program and not submitted with the other tables.

5. Cost allocations must be made left to right on WORKSHEET C.

SPECIFIC:

1. Confirm that the total costs before distribution of facility and administration amounts listed on WORKSHEET B, COLUMN (h) have been transferred to WORKSHEET C, COLUMN (a). If WORKSHEET B is not used, obtain entries for WORKSHEET C, COLUMN (a) from the accounting system.

2. Distribution of Facility Costs:

    a. On WORKSHEET C, transfer the facility costs from LINE 14, COL (a) to LINE 14, COLUMN (d) as a negative number.

b. Determine the total square footage used by each service group and enter the amount on the corresponding line of WORKSHEET C in COLUMN (b). Total the square footage of COLUMN (b) and enter the total on LINE 15.

c. Divide the square footage in COLUMN (b) for each cost center by the total square footage on LINE 15, COLUMN (b) and enter the percentage on the corresponding line of COLUMN (c). Round as necessary to insure that the total of percentages listed on LINE 15, COLUMN (c) is 100 percent.

d. Multiply each percentage obtained in COLUMN (c) by the total facility costs on LINE 14 in COLUMN (d) and enter the results on the corresponding line of COLUMN (d) as positive numbers.

e. Total COLUMN (d) and check to see that the total equals "0" on LINE 15. Note that LINE 14 is a negative number.

3. For each line, add the amounts in COLUMN (a) to the amounts in COLUMN (d) and enter the total in COLUMN (e). Transfer the figures from COLUMN (e), LINES 1b and 13 onto TABLE 6, COLUMN (e) in the two service groups that are not shaded, LINES 1b and 13.

4. Distribution of Administrative Costs:

a. On WORKSHEET C, add the entries on LINES 1 through 10 in COL (e) to obtain the health care cost subtotal for LINE 16, COLUMN (e).

b. Divide each amount listed in COLUMN (e) by the subtotal on LINE 16, COLUMN (e) and enter the percentage obtained on the corresponding line of COLUMN (f). Round the percentage in COLUMN (f) as necessary so that the total percentage on LINE 15, COLUMN (f) equals 100 percent.

c. Transfer the administration costs from LINE 13, COLUMN (e) to LINE 13, COLUMN (g) as a negative number.

d. Multiply the percentage on each line in COLUMN (f) by the total administration cost to be allocated on LINE 14, COLUMN (g) and enter the result on the corresponding line of COLUMN (g) as positive numbers.

e. Total COLUMN (g) and check to see that the total equals "0" on LINE 15. Note that LINE 13 is a negative number.

5. Total amounts on each line on WORKSHEET C, COLUMN (e) and (g), and enter the total for each service group in COLUMN (h).

6. Transfer the amounts from WORKSHEET C, COLUMN (h) to TABLE 6, COLUMN (f).

DEFINITIONS

DISTRIBUTION OF FACILITY COSTS, WORKSHEET C, COLUMNS (b), (c) and (d):
This section of WORKSHEET C is designed to assist programs in the distribution of facility costs to other functional cost centers. The basis for allocation used is the percentage of total square footage used by each cost center applied to the total facility costs.

DISTRIBUTION OF ADMINISTRATION COSTS, WORKSHEET C, COLUMNS (f) & (g):
This section of WORKSHEET C is designed to assist programs in the allocation of administration costs to the health care functions. The basis of allocation is the percentage of total costs (other than administration) by cost center applied to the total administration costs.

CONSISTENCY CHECK:

1. WORKSHEET C: LINE 15, COLUMN (a), COLUMN (e), and COLUMN (h) should be equal.

URBAN INDIAN HEALTH COMMON REPORTING REQUIREMENTS (UCRR)

TABLE 7: ACCOUNTS RECEIVABLE, CHARGES AND COLLECTIONS BY SOURCE OF FUNDS

Program Name: _____

SOURCE OF FUNDS	ACCOUNTS RECEIVABLE AT BEG. OF PERIOD (a)	FULL CHARGES & PREMIUMS (b)	AMOUNT COLLECTED (c)	ADJUSTMENTS (Identify Below) (d)	ACCOUNTS RECEIVABLE AT END OF PERIOD (e)
1) Medicare (Title XVIII)					
2) Medicaid (Title XIX)					
3) Title XX					
4) Other Third Party					
5) Patient Fees/ Premiums					
6) Other Specify: _____					
TOTAL					

OMB No. 0917-0007 Expiration Date: 00/00/00

BREAKDOWN OF ADJUSTMENTS:

~~**Description of Adjustment**~~	$
7) Disallowances & Reductions (Contractual Allowances)	$ _____
8) Sliding Payment Scale Adjustments	$ _____
9) Bad Debt Write-off	$ _____
10) Other (Specify) _____	$ _____
11) Other (Specify) _____	$ _____

TABLE 7: ACCOUNTS RECEIVABLE, CHARGES AND COLLECTIONS BY SOURCE OF FUNDS

INSTRUCTIONS

GENERAL:

1. Table 7 is on a cash basis; it reflects monies actually received during the reporting period.

d. Amounts should be rounded off to the nearest dollar.

e. Negative symbols (parenthesis brackets or minus signs) will normally not be used since most adjustments tend to decrease charges. However, in cases where the intention is to increase the adjustment amount (i.e., collection in excess of gross charges from third parties, or current period collection of a bad debt previously written off), the net of all adjustments is reported on LINE 6, COLUMN (d) and the amount of those adjustments which would increase charges is reported separately on LINE 10 as a negative amount.

f. Accounts receivable at the beginning of the reporting period on LINE 6, COLUMN (a) must equal the accounts receivable on LINE 6, COL (e) at the end of the previous fiscal year.

SPECIFIC:

Accounts Receivable at the Beginning of This Period:

1. Enter the amount from TABLE 7, LINE 6, COL (e) at the end of the previous fiscal year on LINE 6. COLUMN (a) of the current Period TABLE 7.

2. Programs that have not previously submitted a TABLE 7 for the prior period must calculate the beginning accounts receivable balance from the patient ledger cards and/or General Ledger Accounts. The beginning balance should be made as of October 1, the first day of the fiscal year. Enter the beginning balance in COLUMN (a). Programs which are beginning operation and have no previous accounts receivable should enter "0" in COLUMN (a).

Full Charges and Premiums During This Period:

1. Enter the gross amount of charges and premiums for all services rendered during the reporting period, including fee-for-service charges and prepaid premiums in COLUMN (b).

2. Programs which are reimbursed on a cost-based visit or encounter rate and/or capitation rate by Title XIX (Medicaid monies from the Social Security Act) or as a Federally Qualified Health Center under Title XVIII (Medicare monies from the Social Security Act) may use the fiscal intermediary or Health Care Financing Administration negotiated visit/encounter rate or capitation rate as the full charge/premium for the purpose of this table.

3. The amount entered in COLUMN (b) must be the result of fee or premium schedules which reasonably reflect the costs of operations.

TABLE 7 – INSTRUCTIONS (Continued)

Amount Collected During This Period:

1. Enter the total dollar amounts received between October 1 and the ending date of the reporting period in COLUMN (c).

Adjustments:

1. Disallowances and Reductions (Contractual Allowances): If a third party (such as Title XV111, XIX or private insurance) reimburses less than the organization's cost or full charge and the program cannot bill the patient for the remainder, enter the remainder or reduction under adjustments, LINE 6, COLUMN (d) and on LINE 7, disallowances and reductions.

   Amounts in excess of the reimbursable amount from a third party payor, but not in excess of the program's established charges, should remain as full charges of another third party or private individual can be billed for the difference.

2. Sliding Payment Scale Adjustments: Reductions to patient fees/ premiums because of the patient's inability to pay, as determined by the program's sliding scale, should be recorded separately on LINE 8, and included in the net payment adjustments, LINE 6, COL (d).

3. Bad Debt Write-Off: Reductions of the net collectible amount after all other adjustments should be recorded on LINE 6, COL (d) and on LINE 9. Bad debt write-offs may occur due to the program's inability to locate persons, the patient's refusal to pay or the patient's inability to pay after the sliding fee scale is applied.

4. Other Adjustments: Any other adjustments should be specified according to type on LINE 10 and included on LINE 6, COLUMN (d). Care must be exercised in using negative symbols for adjustments. COLUMN (d) normally represents a reduction in accounts receivable, negative symbols should not be used unless the net adjustment is an increase in accounts receivable.

Accounts Receivable at the End of This Period:

1. The accounts receivable ending balance should be calculated and recorded on LINE 6, COLUMN (e), and compared to the total of the patient ledger cards as of September 30 to ensure inclusion of all data and verification of the ending balance.

Completion of TABLE 7:

1. Total all adjustments by type (LINES 7, 8, 9 and 10) and ensure that the total agrees with LINE 6, COLUMN (d).

2. Verify consistency checks.

CONSISTENCY CHECKS:

1. COLUMN (e) should equal COLUMN (a) + COLUMN (b) - COLUMN (c) - COLUMN (d).

2. The amount entered in COL (a) should equal the amount entered in COL (e) of the TABLE 7 for the preceding fiscal year.

DEFINITIONS

ACCOUNTS RECEIVABLE: The collectable amount due the at the end of the reporting period from patients and/or third party payers for services rendered.

FULL CHARGES AND PREMIUMS: The gross charges as established by the program for the particular types of services rendered. Full charges are calculated on a 100 percent pay basis for all services prior to any adjustments. These amounts should be reasonably related to the cost of operations. Full charges can be calculated at a cost-based, negotiated visit/encounter rate or capitation rate.

AMOUNT COLLECTED: Cash collected during the reporting period for services rendered, regardless of the period in which those services were provided.

ADJUSTMENTS: Accounting transactions reflecting the differences between the full charges generated by the program versus the amount actually received (amount collected) and/or the amount expected to be received in the near future (accounts receivable). Amounts for which another third party or private individual can be billed are not considered adjustments and should be recorded or reclassified as full charges due from the secondary source of payment. These amounts will then be classified as adjustments when all sources of payment have been exhausted and further collection is not anticipated. If an allowance for doubtful accounts is maintained, the corresponding expenses should be recorded as adjustments. Adjustments are classified by type of transaction.

> Disallowances and Reductions (Contractual Allowances): The difference between the program's customary charges and the amount allowed by third party payers for the billed services.
>
> Sliding Payment Scale Adjustments: Reductions to full (gross) charges, or to the amounts transferred to patient fees from third party payers, based upon the program's sliding fee scale.
>
> Bad Debt Write Off: The amount of net charges (gross charges) less disallowances, reductions and sliding fee scale adjustments which are not expected to be collected.

Other (Specify): Any other type of adjustment, such as recovery of bad debt, staff discounts, free immunizations, senior discounts, etc.

TABLE 8: SUMMARY OF FISCAL YEAR INCOME AND EXPENSES

Program Name: _____

SOURCE OF INCOME	AMOUNT BOOKED
A. FEDERAL GRANT FISCAL YEAR INCOME (Including Deferrals):	
1) Section 329, 330, and 340 (Public Health Service Act)	
2) Maternal & Child Care Block Grants	
3) Title X (Public Health Care Service Act)	
4) WIC (Supplement Food for Women, Infants, & Child Program Act)	
5) IHS - Title V (Indian Health Care Improvement Act)	
6) IHS - Urban Substance Abuse Grants	
7) IHS - Other (Specify):	
8) Other (Specify):	
B. GRANT & STIPEND INCOME FROM OTHER SOURCES	
9) State	
10) County	
11) City	
12) Other (Specify):	
C. ACCRUED THIRD PARTY REIMBURSEMENTS	
13) Title XVIII (Medicare)	
14) Title XIX (Medicaid)	
15) Title XX	
16) Other Third Parties	
17) Patient Collections	
18) TOTAL FISCAL YEAR INCOME	

TYPE OF EXPENSE	AMOUNT BOOKED
EXPENSE:	
1) Capital Expense	
2) Non-Capital Expense	
3) TOTAL	

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TABLE 8: SUMMARY OF FISCAL YEAR INCOME AND EXPENSES

INSTRUCTIONS

GENERAL:

1. This table applies to all income and expenses associated with the health services and activities incorporated in the program's approved application for IHS funding, including those associated with the delegate agency operations.

2. Amounts should be rounded to the nearest dollar.

3. Negative symbols (parenthesis, brackets, minus signs) should not be used.

4. This is an accrual basis table, not a cash basis table. All monies billed during the period and all monies expended for costs incurred during the period must be reported, regardless of the period in which:
   a. the income was or will be received;
   b. the grant(s) funds or contract(s) funds was(were) received or will be received; or
   c. the bill for the expenditure was paid.

SPECIFIC:

SOURCE OF INCOME

FEDERAL GRANT FISCAL YEAR INCOME (Including Deferrals)

1. Record all income (i.e., monies due), either direct or indirect, of Federal grant and contract monies by classification on LINES 1 through 7. Do not include monies received for food on LINE 4, WIC.

2. Specify any other Federal grant(s) and contract(s) in the space provided and record the total amount due from these grant(s) and contract(s) on LINE 8.

GRANT & STIPEND INCOME FROM OTHER SOURCES

1. Record all state, county and city grant and contract income on LINES 9 through 11, respectively. Do not include Federal grants that were awarded to state and local agencies on LINES 9 through 11. These should be included as indirect income of Federal grants through delegate relationships and reported on the appropriate line for Federal grants (LINES 1 through 8).

2. Specify all other sources and record the amounts billed during the reporting period from those sources on LINE 12. Use a footnote if insufficient space is available to record the names of the sources and include the total amount on LINE 12. Include loan proceeds in this total.

TABLE 8 – INSTRUCTIONS (Continued)

ACCRUED THIRD PARTY REIMBURSEMENTS

1. Record all public billings made during the period for patient services as classified by source on LINES 13 through 15.

2. Record all other third party billings made during this period for patient services on LINE 16.

3. Record all billings to patients made during this period for patient services on LINE 17.

TOTAL FISCAL YEAR INCOME

4. Total LINES 1 through 17 and enter the sum on LINE18.

TYPE OF EXPENSE

EXPENSE

1. List the dollar amount expended for the purchase of capital assets on LINE 1. This total includes the full purchase price (capitalization amount), including amounts paid directly by a lending institution to the vendor. The difference between the purchase price and the amount financed (borrowed) should equal the amount of any down payment made directly by the borrower to the vendor. The sum of the payments to the vendor are included in the amount on this line.

2. LINE 2 includes all expenditures made during the reporting period which cannot be classified as capital expenditures. Include payments made to the Federal Government for the cost of NHSC assignees and all operating expenditures which were made during the period. Payments to lenders toward the retirement of the principal, as well as interest, taxes, insurance and escrow amounts which are included in the monthly (or other) payments are included on this line.

3. Total LINES 1 and 2 enter the sum on the LINE 3.

DEFINITIONS

FEDERAL GRANTS FISCAL YEAR INCOME: Federal monies received as grants or contracts to support health care access and delivery.

> Section 329. 330 and 340 (Community Health Center): Monies received directly from DHHS in the form of a grant under Sections 329 and 330, and/or 340 of the Public Health Service Act. These grants include Community Health Center, Rural Health Initiative, Health Care for the Homeless, Migrant Health Center, Urban Health Initiative, and Hospital-Affiliated Primary Care Center Programs.
>
> MCH Block Grants: Monies received directly from DHHS or indirectly as a delegate

agency under a block grant under Title V of the Social Security Act for the Maternal and Child Health Program.

Title X (Family Planning): Monies received directly from DHHS in the form of a grant or indirectly through a delegate agency relationship under Title X of the Public Health Service Act.

WIC: Monies received from the applicable State agency for the administration and operation of Supplement Food for Women, Infants and Children Program activities. Does not include monies received for food.

IHS Title V (Urban Indian Health Care): Monies received directly from DHHS in the form of a grant or contract under Title V of the Indian Health Care Improvement Act.

IHS-Urban Substance Abuse Grants: Monies received directly from DHHS in the form of a grant under Section 4231 of the American Indian Alcohol and Substance Abuse Treatment and Prevention Act.

IHS Other: Any Indian Health Service grants or monies received under legislation other than those under Title V of the Indian Health Care Improvement Act.

Other Federal Grants: Any Federal grants or monies received under legislation other than those defined above which are used to support health care access and delivery.

GRANT & STIPEND INCOME FROM OTHER SOURCES: Monies received from state, local, private, or other sources to support health care access and delivery,

State: Monies received from State governments, other than under Title V (MCH) and Title X (Family Planning) of the Social Security Act or WIC funds. This includes any State portions of Revenue Sharing.

County: Monies received from county governments, including that government's portion of Revenue Sharing monies.

City: Monies received from city governments, including that government's portion of Revenue Sharing monies.

Other: Monies received from sources other than those listed previously, including:

- Proceeds from borrowing, regardless of the lender (local, State, Federal or private agencies);
- Gifts, donations or grants from private foundations, groups or individuals;
- Proceeds from the sale of capital assets; and
- National Health Service Corps (NHSC) loans.

TABLE 8 – DEFINITIONS (Continued)

ACCRUED THIRD PARTY REIMBURSEMENTS: Monies received on a fee-for-service, per visit, or prepaid
basis as payment for services provided.

Title XVIII (Medicare): Monies billed on a fee-for-service, per visit, or prepaid basis for services provided under Title XVIII of the Social Security Act either directly from the Bureau of Health Insurance or through a fiscal intermediary.

Title XIX (Medicaid): Monies billed on a fee-for-service, per visit, or prepaid basis from the State Agency which administers Title XIX of the Social Security Act or from its fiscal intermediary.

Title XX: Monies billed for social services and family planning for children and families eligible under Title XX of the Social Security Act.

Other Third Parties: Monies billed on a fee-for-service, per visit, or prepaid basis from private insurance firms or groups. This includes all monies billed directly from Blue Cross and Blue Shield and other private insurance; group contracts with unions and employers; CHAMPUS; and employment/social group affiliated contracts.

Patient Collections: Monies billed directly to patients and/or their families on a fee-for-service, per visit or prepaid basis.

EXPENSES: Monies expended for the operation of the health care access and delivery program.

Capital Expense: Monies expended for the purchase of all fixed assets (based on the program's capitalization policy, but must include all items purchased during the period which have a historical unit cost of $1,000 or more and a useful life of more than one year).

Non-Capital Expenditures: All monies expended for purposes other than the purchase of capital (fixed) assets, including:

- Salaries, contracts, and all operating expenses paid during the period;
- All interest, taxes, insurance and principal associated with the retirement of debt paid during the period; and
- Amounts expended for supplies, insurance and non-capital assets, including consumable supplies which were purchased and paid for during the period but may still be in inventory at the end of the period and insurance premiums paid during the period for a policy which may cover a period extending beyond the end of the reporting period.

EXHIBIT A EXAMPLES OF PROVIDER TYPES BY SERVICE GROUP

SERVICE GROUP & PROVIDER TYPE	TYPES OF PERSONNEL
1) MEDICAL	
a) Physicians	General Practitioner
	Family Practitioner
	Internist
	Pediatrician
	Psychiatrist
	Allergist
	Cardiologist
	Dermatologist
	Orthopedist
	Surgeon
	Urologist
	Opthamologist
	Other Specialist & Sub-Spedialist
b) Mid-Level Practitioners	Child Health Associate
	Medex
	Physician's Assistant
	Physician's Associate
	Nurse Practitioner
	Women's Health Care Specialist
c) Nurses (Medical)	Home Health Nurse
	Clinical Nurse Specialist
	Registered Nurse (RN)
	Licensed Practical Nurse (LPN)
	Licensed Vocational Nurse
d) Medical Support	Nurse Aide/Assistant
	Clinic Aide/Assistant
	Team Clerk
	Team Secretary
	Appointment Secretary
2) OBSTETRICS/GYN./PRENATAL	
a) Physicians	Obstetrician/Gynecologist
	General Practitioner
	Family Practitioner
	Pediatrician
	Surgeon
b) Mid-Level Practitioners	Child Health Associate
	Medex
	Physician's Assistant
	Physician's Associate
	Nurse Practitioner
	Certified Nurse-Midwife
	Women's Health Care Specialist
c) Nurses (Medical)	Home Health Nurse
	Clinical Nurse Specialist
	Registered Nurse (RN)
	Licensed Practical Nurse (LPN)
	Licensed Vocational Nurse
d) Medical Support	Nurse Aide/Assistant
	Clinic Aide/Assistant
	Team Clerk
	Team Secretary
	Appointment Secretary

EXHIBIT A EXAMPLES OF PROVIDER TYPES BY SERVICE GROUP (Continued)

SERVICE GROUP & PROVIDER TYPE	TYPES OF PERSONNEL
3) ANCILLARY SERVICES	
a) Laboratory (Medical)	Pathologist
	Medical Technologist
	Laboratory Technician
	Laboratory Assistant
	Phlebotomist
b) Imaging (Medical)	Radiologist
	Imaging Technologist
	Imaging Technician
c) Pharmacy (Medical & Dental)	Pharmacist
	Pharmacist Assistant
4) DENTAL	
a) Dentists	General Practitioner
	Specialists
	Oral Surgeon
	Pedodontist
b) Dental Hygienists/Oral Therapists	Dental Hygienist
	Oral Therapist
c) Dental Support	Dental Assistant
	Dental Technician
	Dental Aide
	Team/Appointment Secretary
5) HEALTH EDUCATION	
a) Health Education Providers	Health Educator
	Family Planning Counselor
	Medical Social Worker
	Public Health Nurse
	AIDS Educator
b) Health Education Support	Health Education Aide
6) NUTRITION SERVICES	
a) Nutrition Providers	Nutritionist
	Dietician
b) Nutrition Support	Dietary Technician
	Nutrition Aide
7) BEHAVIORAL SERVICES	
a) Mental Health Counselors	Psychologist
	Psychiatric Nurse
	Mental Health Nurse
	Marriage, Family, Child Counselor
b) Substance Abuse Counselors	Drug/Alcohol Counselors
	Inpatient/Outpatient Counselors
	Substance Abuse Psychologist/Psychiatrist
c) Social Services Providers	Psychiatric Social Worker
	Clinical Social Worker
	Licensed Social Workers
d) Behavioral Services Support	Counseling Aide
	Team/Appointment Secretary

EXHIBIT A EXAMPLES OF PROVIDER TYPES BY SERVICE GROUP (Concluded)

SERVICE GROUP & PROVIDER TYPE	TYPES OF PERSONNEL
8) OTHER ALLIED HEALTH SVCS.	
a) Other Allied Health Svcs. Providers	Public Health Nurse/Visiting Nurse
	Home Health Aide
	Chiropractor
	Speech Pathologist
	Audiologist
	Podiatrist
b) Other Allied Health Svcs. Support	Team/Appointment Secretary
c) Optical Service Providers	Optometrist
	Optician
	Optometric Assistant/Technician
d) Traditional Indian Medicine	Traditional Indian Medicine Providers
9) COMMUNITY HEALTH SVCS.	
a) Community Services Providers	Community Health Worker
	Family Health Worker
	Outreach Worker
	Community Health Advocate
b) Community Services Support	Community Health Aide
	Team/Appointment Secretary
10) ENABLING SERVICES	
a) Case Managers (of referrals)	Case Managers
b) Eligibility Support	Benefits Coordinator
c) Employment/Housing Support	Occupational Therapist
d) Child Care (during visits)	Baby Sitter
e) Transportation (for visits)	Transportation Worker
f) Interpreters	Interpreter
g) Other Enabling Services	Team/Appointment Secretary
11) PROGRAM OVERHEAD	
a) Patient Records	
b) Administration	
c) Facility	

EXHIBIT B LIST OF EXAMPLES OF CLINIC OVERHEAD COSTS

COST ITEM	SERVICE GROUP
Program Management	Administration
Clerical, Accounting & Bookkeeping	Administration
Legal Services	Administration
Record Keeping	
Patient Records	Health Care
Other	Administration
Computer Costs	
Patient Records	Health Care
Other	Administration
Registration & Reception (not appointments)	Administration
Marketing	Administration
Billing, Payroll & Personnel Systems	Administration
Training Activities	Administration[1]
Clinical Quality Assurance Activities	Health Care
Office Supplies	Administration
Office Equipment (including depreciation)	Administration
Telephone & Telegraph	Administration[2]
Postage & Freight	Administration
Membership Dues & Subscription	Administration[1]
Travel	Administration[1]
Indirect Cost Agreement[3]	Administration
Payroll Taxes	All Cost Centers with Salaried Personnel
Property & Other Taxes	Administration
Insurance	
Bonding (employee & board)	Administration
Facilities (liability)	Facility
Malpractice	Health Care
Custodial & Janitorial Costs	Facility
Security Equipment and Personnel	Facility
Preventative Maintenance & Minor Repairs	Facility
Depreciation of Fixed Equipment	Facility
Depreciation of Building & Renovation	Facility
Use & Maintenance of Physical Plant	Facility
Space Rental	Facility
Utilities	Facility

' Costs that are not directly supportive or that cannot be assigned to a specific health care service group.

[2] Documented long distance calls for consultation are assigned to health care service group.

[3] Reimbursement for indirect costs based upon a fixed percentage rate applied to a known expense amount and approved by DHHS.

EXHIBIT C

ADJUSTMENTS NECESSARY TO CONVERT COSTS FROM CASH TO ACCRUAL BASIS FOR TABLE 6

ADDITIONS TO CURRENT PERIOD EXPENDITURES:

PRIOR PERIOD EXPENDITURES CONSUMED IN, OR ALLOCATED TO, THE CURRENT REPORTING PERIOD.

1. Depreciation expense on capital items.

2. The portion of prepaid expenses (insurance, rent, interest, taxes) consumed during this period but paid for prior to this period.

CONSUMPTION DURING THE CURRENT REPORTING PERIOD OF GOODS AND SERVICES WITHOUT A CORRESPONDING CURRENT PERIOD EXPENDITURE.

1. Accounts payable and/or accrued expenses.

2. The fair market value (FMV) of donated goods and services consumed during the period.

3. Depreciation expense calculated from the (FMV) assigned to capital, items acquired by donation.

DEDUCTIONS FROM CURRENT PERIOD EXPENDITURES:

EXPENDITURES FOR GOODS AND/OR SERVICES NOT CONSUMED DURING THE REPORTING PERIOD.

1. Expenditures for capital items.

2. The portion of expenditures for prepaid items made during this period for which partial or total benefit will be derived in a future period.

3. Expenditures for the retirement of the principal on outstanding debts.