COLORADO
Department of Health Care Policy & Financing

Department of Health Care Policy & Financing
1570 Grant Street
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COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING MEDICAL ASSISTANCE PROGRAM

MEDICAID COST REPORT INSTRUCTIONS FOR FEDERALLY QUALIFIED HEALTH CENTERS

EFFECTIVE DATE

JANUARY 1, 2023

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

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INTRODUCTION

Medical Assistance Programs and Federally Qualified Health Centers

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

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

FQHC costs related to medical services provided must be allowable, allocable, reasonable and given consistent treatment within the accounting records. Medical services provided include general services for outpatient primary care, emergency services, and services provided through agreements or arrangements, such as physician services or additional and specialized diagnostic and laboratory services not available at the FQHC[1]. Allowable costs include compensation of provider staff, costs of services and supplies related to services delivered by provider staff, overhead costs and costs of services purchased by the FQHC[2]. Unallowable costs include, but are not limited to, expenses incurred by an FQHC that are not for the provision of covered services, according to the laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per-visit encounter rate for Medicaid clients[3].

Reimbursement and Rate Calculation

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

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

Duplicate encounters of the same service category occurring on the same day and at the same location are prohibited.

[1] 10 CCR 2505-10 8.700.3.A
[2] 10 CCR 2505-10 8.700.5.A
[3] 10 CCR 2505-10 8.700.5.B

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

A distinct specialty behavioral health encounter is generated when:

a. Rendered services are included in the six sessions of Short Term Behavioral Health services reimbursed directly by the Department, or

b. The services are covered by a contracted Regional Accountable Entity (RAE). The following procedure codes are covered by the RAE: 00104, 90785, 90849, 90853, 90875, 90876, 90887, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96372, 96535, 97537, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, G0176, G0177, H0006, H0015, H0017, H0018, H0019, H0020, H0033, H0034, H0035, H0036, H0037, H0038, H0039, H0040, H0043, H0044, H0045, H2001, H2012, H2014, H2015, H2016, H2017, H2018, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2030, H2031, H2032, H2033, S3005, S5150, S5151, S9445, S9480, S9485, T1005, and T1017.

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

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

Effective March 1, 2020, visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor.

Group sessions do not generate a billable encounter for any FQHC services[4], and do not meet the definition of a visit. The costs for services delivered by the providers listed above are included as covered health care costs on the cost report and the related visits cannot be billed in any other manner than via the annually established encounter rate. There may be Medicaid-covered services that are delivered by a provider not listed above. If so, these costs are also included in the cost report, even though there is no billable encounter.

The costs and visits associated with Family Planning services included in the Department's Family Planning benefit should be included in the cost report. Costs associated with carved out (Long Acting Reversible Contraceptives) and non-covered Family Planning services (including birthing and parenting classes, infertility treatments, sterilization reversal, and three- and four-dimensional ultrasounds) should be reported on Worksheet 1, Section A, Subsection 4. See the instructions for Worksheet 1 for more

[4] 10 CCR 2505-10 8.700.1

details.

The Department gathers claims data related to visits, carved-out services, pharmacy, and ACC PMPM beneficiaries. During the cost report audit, this data is compared to the information submitted by the FQHC. If there are significant discrepancies, the cost report auditor will follow up with the FQHC to either ask for an explanation of the discrepancy or for the FQHC to update their information. If needed to resolve discrepancies, Department data will be provided by the Department upon request. Visit data is collected by counting the visits paid by the Department or Managed Care Entities for dates of service during the cost report period. Information related to carved-out services and pharmacy is collected by summarizing the billed and paid amounts for these services and comparing the cost to what is reported in the cost report, taking into account the fact that the cost data the Department has is Medicaid/CHP only and the FQHCs are reporting total cost for all payers. ACC PMPM data is collected by counting the number of attributed member months. Only the base payments received by the FQHCs need to be offset from the cost report. The base payment is the minimum amount paid for each member. Many RAEs pay a different amount for geographically attributed than for non-geographically attributed members, or other factors may dictate varying payment amounts for members. The minimum amount received on an individual member basis should be used to calculate the amount to offset.

After the cost report has been finalized, the Department and their cost report auditor (contractor) will calculate the new Prospective Payment System (PPS) and Alternative Payment Method (APM) rates. Along with an all-inclusive APM rate, a separate APM rate will be calculated for physical health, dental health, and specialty behavioral health services. The final APM rates will be the lower of the rates calculated from the current year cost/visit data and the base rates.

Base rates will be the audited, calculated, inflated, and weighted average encounter rate for each separate rate for the past three years. Base rates are recalculated (rebased) annually. Initial base rates shall be calculated when the Department has two year's data of costs and visits. The FQHC can either select their APM rates or their PPS rate to be their final encounter rate. FQHCs must complete and send their payment methodology agreement form back within 10 days after receipt of their rate letter. In the event that the PPS rate is greater than the calculated all-inclusive APM rate, and the FQHC has selected their APM rates, there will be a process to reconcile final reimbursement to the PPS rate.

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

The new encounter rate shall be effective 120 days after the FQHC's fiscal year end if it is less than the old encounter rate. However, if the new encounter rate is greater than the old encounter rate, the old encounter rate shall remain in effect for an additional day above the 120-day limit for each day the cost report package is submitted late[5]. The cost report package is described in the Cost Report Forms section of these instructions.

[5] 10 CCR 2505-10 8.700.6.D

General Cost Reporting Principles

FQHCs are required to follow these overarching principles when preparing the cost report:

1) The cost report must reflect the same fiscal period as the audited financial statements.

2) Total expenses on the cost report must reconcile with the FQHC's audited financial statements.

3) All costs must be reported on the accrual basis of accounting and only costs for the reporting period may be included; costs from other periods are unallowable.

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

5) All FQHC costs are reported on the cost report, including unallowable costs and costs for certain services and supplies billed outside of the encounter rate.

   a. Unallowable costs must be reported on Worksheet 1, Section A, Subsection 4, or Worksheet 1 Section B, Subsection 2 of the cost report, with some costs then being adjusted out of the cost report, as appropriate.

   b. The costs for services and supplies billed outside of the encounter rate must be reported on Worksheet 1, Section A, Subsection 4 of the cost report. A list of services and supplies for which the FQHC may bill outside of the encounter rate is included in the *Worksheet 1* section of these instructions.

6) Revenue received through a Medicaid grant for Medicaid client services must be offset against expense on the cost report to prevent duplicative Medicaid payments for services rendered.

7) The cost associated with providing group sessions may be included in the cost report, even though the associated visits cannot be billed as an encounter and are not reported as a visit on Worksheet 3.

8) A portion of employee time and/or physical space dedicated to an unallowable cost must be reclassified to a non-reimbursable cost center if there is a measurable amount of time and/or space.

Cost Report Filing Requirements

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

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

Newly designated FQHCs shall file a preliminary cost report with estimated data, or actual data if

available. The data from the preliminary cost report shall be used to set a reimbursement base rate for the first year. The Department will determine a newly designated FQHC's PPS rate based on the first full year of actual cost and visit data from the FQHC cost report after designation as an FQHC.

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

Cost Report Forms

Current Medicaid cost report forms will be distributed to FQHCs in January of each year. (See *Appendix A* for a complete set of forms.) The line numbers and cost center descriptions on the preprinted form should be used as formatted and not changed.

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

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

The following rounding standards should be used for fractional computations:

a. Round to 2 decimal places
    - Rates
    - Cost per visit

b. Round to 6 decimal places
    - Ratios
    - Limit adjustments

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

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

- Statistical Data and Certification Form
- Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses
- Worksheet 1 – Supplement 1 – Reclassifications
- Worksheet 1 – Supplement 2 – Adjustments to Expenses
- Worksheet 2 – Allocation of Expenses
- Worksheet 3 – FQHC Provider Staff, Visits and Productivity

- Worksheet 4 – Determination of FQHC Encounter Rates
- Worksheet 5 – Revenues
- Addendum 1 – Encounter Report
- Addendum 2 – Unallowable Expenses
- Addendum 3 – Administration Breakdown
- Addendum 4 – COVID-19 Vaccine Administration Calculator
- Addendum 5 – ACC PMPM Offset Calculator

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

- Audited financial statements
- Working trial balance with crosswalk (see example in *Appendix B)*
- Full Time Equivalents (FTE) report by department for all staff of the FQHC (see example in *Appendix B*)
- Completed Pharmacy Overhead Allocation Form (see also *Appendix C*; the Excel version of the Pharmacy Overhead Allocation Form may be found here.)

Submission of the Cost Report

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

Submissions can be emailed to: infosubmit@mslc.com
Submissions can be mailed to: Myers and Stauffer LC
Attn: FQHC Cost Reports
6312 S. Fiddlers Green Circle, Suite 510N
Greenwood Village, CO 80111
Phone 303-694-3605

Maintenance of Records

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

Informal Reconsideration and Appeal

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

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

Andrew Abalos
Facility Rates Section Manager
Fee-for-Service Rates Section
Department of Health Care Policy & Financing
1570 Grant Street
Denver, CO 80203

Final Approval

Upon completion and approval of the cost report, the Contractor will provide the FQHC with a copy of the final adjusted cost report, as well as final adjusting entries and supporting calculations/rationale for the adjusting entries.

STATISTICAL DATA AND CERTIFICATION FORM

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

Section 1 – Cost Report Submission and FQHC Data
Report the date the cost report is submitted to the Department's contractor. Report the full legal name and address of the FQHC. Include the phone number, fax numbers and name/email address for the cost report contact. The "Date Received" should be left blank and will be completed by the Department's contractor upon receipt.

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

Section 3 – Reporting Period
Report the beginning date and end date of the reporting period. This should coincide with the FQHC's fiscal year.

Section 4 – Type of Control
Select the type of control using the drop-down menu in the appropriate area.

Section 5 – Other Federally Qualified Health Centers, Providers of Service including Rural Health Clinics, Hospitals, Skilled Nursing Facilities, Home Health Agencies, Suppliers or Other Entities that are owned or related through Common Ownership or Control to the Individual or Entity
Report all entities that are owned by, or related through common ownership or control to, the FQHC (i.e. other FQHCs, rural health clinics, hospitals, skilled nursing facilities, home health agencies, suppliers, etc.).

Section 6 – Source of Federal Funds
Report the type of Federal funding awarded to the reporting FQHC by placing an X next to each source of funding.

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

WORKSHEET 1

Reclassification and Adjustment of Trial Balance of Expenses

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

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

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

Costs for services not reimbursed via the encounter rate are "carved out" of the cost report. These costs are either reimbursed to the FQHC on a fee-for-service basis or via a separate billing number (e.g. pharmacy), depending on the type of cost. These costs are reported on Worksheet 1, Section A, Subsection 4 of the cost report. "Carved out" services include:

- Pharmacy
- Long Acting Reversible Contraception (LARC) devices
- Services provided to patients on an inpatient basis in a hospital
- Dentures and partial dentures
- Dental services provided to patient on an outpatient basis in a hospital
- Services provided under the Prenatal Plus Program
- Services provided under the Nurse Home Visitor Program
- Offsite Laboratory/X-Ray/Specialty Care Office Visits
- Antagonist injections for substance use disorder (e.g. Vivitrol)
- COVID-19 vaccine administration
- COVID-19 monoclonal antibody infusion
- COVID-19 antiviral medication (Remdesivir)
- Other patient services not covered by Colorado Medicaid
- Movable equipment for non-reimbursable services

Costs for services that are not covered are reported as non-reimbursable costs on Worksheet 1, Section A, Subsection 4 of the cost report. Examples of services that are not covered include the following:

- Chiropractic services
- Alternative medicine such as acupuncture
- Investigative and experimental treatments
- Lamaze, birthing and parenting classes

- Infertility treatments
- Spermicide, female condoms, home pregnancy tests
- Sterilization reversal
- Ultrasounds performed only for determination of the sex of the fetus or to provide a keepsake photo
- Three- and four-dimensional ultrasounds
- Paternity testing
- Home tocolytic infusion therapy

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

Columns of Worksheet 1

Columns 1 through 5
These columns identify costs in accordance with the accounting records. The FQHC must present a crosswalk from the accounting system-generated trial balance to the lines on Worksheet 1. See *Appendix B* for an example.

Column 1 – Compensation
Cost of salaries and wages paid to FQHC employees.

Column 2 – Fringe Benefits
Cost of fringe benefits paid on behalf of FQHC employees. It is acceptable for fringe benefits to be pro-rated to cost centers based upon salary figures. Fringe benefits includes FICA, Medicare, health insurance, disability insurance, profit sharing, unemployment, worker's compensation, continuing medical education if specific to medical providers, dues and subscriptions if part of the provider contract, other benefits, etc.

Column 3 – Purchased & Contract Services
Cost of contracted services paid other than to employees (i.e. locum tenens providers, laboratory, radiology, janitorial, etc.).

Column 4 – Other

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

Column 5 – Total

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

Column 6 – Reclassifications

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

Reclassification amounts on Worksheet 1 Column 6 are automatically populated from the reclassification detail on Worksheet 1 – Supplement 1 (Reclassifications), which is provided to identify the reclassifications necessary for proper cost allocation. Detailed instructions regarding reclassifications of expense can be found in the *Worksheet 1 – Supplement 1* section of these instructions.

Column 7 – Reclassified Trial Balance

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

Column 8 – Adjustments Increase or (Decrease)

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

Adjustment amounts on Worksheet 1, Column 8 are automatically populated from the adjustment detail on Worksheet 1 – Supplement 2 (Adjustments to Expenses), which is provided to identify adjustments necessary for proper cost allocation. The total of Column 8 must equal the total of adjustments recorded on Worksheet 1 – Supplement 2. Further instructions regarding adjustments of expense can be found in the *Worksheet 1 – Supplement 2* section of these instructions.

Column 9 – Net Expense

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

Lines of Worksheet 1

Section A: Direct Patient Care Costs

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

Subsection 1: Covered Physical Health Costs

Line 1 – Physicians

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

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

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

Line 2 – Physicians Assistants

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

Line 3 – Nurse Practitioners

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

Line 4 – Nurse Midwife

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

Line 5 – Podiatrists

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

Line 6 – Other Nurses (RN/LPN)

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

Line 7 – Medical Assistants/Nurse Aides

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

Line 8 – Interns/Residents
Costs incurred for interns and residents who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Lines 9-13 – Other Behavioral Health Services
Costs reported in this section should reflect the cost for behavioral health services not reimbursable through either the RAEs or the six (6) Short Term Behavioral Health (STBH) visits. The cost of behavioral health professional providing integrated or joint visits that do not generate a separate behavioral health visit are reported in this section. Cost associated with behavioral health services provided to patients which are included in the behavioral health capitation as RAE covered services and six (6) Short Term Behavioral Health (STBH) services are reported in the specialty behavioral health section Subsection 3, Covered Specialty Behavioral Health Costs Lines 36 - 41, regardless of payer.

Line 9 – Psychiatrist (Non-RAE/STBH Services)
Costs incurred for psychiatrists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Covered Specialty Behavioral Health Costs section.

Line 10 – Licensed Clinical Psychologists (Non-RAE/STBH Services)
Costs incurred for licensed clinical psychologists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Covered Specialty Behavioral Health Costs section.

Line 11 – Licensed Clinical Social Workers (Non-RAE/STBH Services)
Costs incurred for licensed clinical social workers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Covered Specialty Behavioral Health Costs section.

Line 12 – Other Licensed Behavioral Health Providers (Non-RAE/STBH Services)
Costs incurred for licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, other licensed behavioral health providers who are furnishing direct healthcare services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Covered Specialty Behavioral Health Costs section. This includes psychiatric social workers, psychiatric nurse practitioners, family therapists, licensed marriage and family therapists, licensed professional counselors and licensed addiction counselors and other licensed Master's Degree-prepared clinicians.

Line 13 – Other Behavioral Health Providers (Non-RAE/STBH Services)
Costs incurred for other behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors and not otherwise included in the Covered Specialty Behavioral Health Costs section.

Line 14 – Laboratory Medical
Costs incurred for in-house laboratory services including staff salary, fringe benefits and supplies. Do not include off-site laboratory costs on this line as they are to be reported in the Non-Reimbursable Patient Services Costs section of the cost report. If the FQHC can demonstrate through contract with

the off-site laboratory that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with that service may remain in the cost report.

Line 15 – X-Ray Medical
Costs incurred for in-house radiology services including staff salary, fringe benefits and supplies. Do not include off-site radiology costs on this line as they are to be reported in the Non-Reimbursable Patient Services Costs section of the cost report. If the FQHC can demonstrate through contract with the off-site radiology contractor that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with that service may remain in the cost report.

Line 16 – Physical Therapy
Costs incurred from services provided by a physical therapist. Physical therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter. Visits for physical therapy services delivered by an approved provider (e.g. physician, physician assistant, or nurse practitioner) may be billed via the encounter rate.

Line 17 – Occupational Therapy
Costs incurred from services provided by an occupational therapist. Occupational therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 18 – Vocational Therapy
Costs incurred from services provided by a vocational therapist. Vocational therapists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 19 – Speech Pathology
Costs incurred from services provided by a speech pathologist. Speech pathologists are not approved providers under the FQHC encounter rate methodology and do not generate an FQHC encounter.

Line 20 – Health Education
Costs incurred for delivery of health education information or materials directly to patients. Included are healthy diet programs and nutritional counseling if performed by a registered dietician, smoking cessation programs, etc.

Line 21 – Medical Supplies
Costs incurred for the purchase and utilization of medical supplies in the FQHC clinics.

Line 22 – Optometry
Costs incurred for optometrists and the purchase and utilization of optometry supplies in the FQHC clinics.

Line 23 – Pharmaceuticals Incident to a Medical Service
Costs for pharmaceuticals that are used incident to a provided service (aspirin, vaccines, etc.).

Line 24 – Medical Movable Equipment
Costs for the purchase of small equipment utilized to deliver clinical services to patients under the Federal capitalization threshold of $5,000.

Additionally, the cost of movable medical equipment, including rental and depreciation of medical equipment, is reported in this cost center. Medical equipment allowed in this cost center is limited to movable medical equipment used to provide medical services, treatments, and diagnostics. Examples include ultrasound machines, beds, autoclaves, defibrillators, and wheelchairs. If the FQHC is able to identify interest expense associated with specific assets in this cost center (such as a capital lease), the interest expense may also be included in this cost center. However, allocations of interest expense are not allowed in this cost center if the FQHC is unable to tie interest expense to a specific asset with third party documentation.

Furniture and décor, including those located in exam rooms, are not considered medical equipment and may not be included in this cost center. No fixed equipment may be included. Additionally, software and computer equipment are not included in this cost center.

Line 25 – Medical Equipment Repairs & Maintenance
Costs for minor repairs and maintenance to equipment utilized to deliver clinical services to patients.

Line 26 – Clinical Pharmacists
Cost incurred for clinical pharmacists who are furnishing comprehensive medication services to patients, including, but not limited to evaluating patient conditions, consulting with providers, and providing recommendations regarding medication therapy including those employed by the FQHC as well as those who work as independent contractors. Do not include unallowable pharmacy costs, such as costs associated with pharmacists working in the retail pharmacy.

Line 27 – Other Physical Health
This cost center is to be used to report any other physical health covered health care costs that do not fit on Lines 1 through 26 and do not have another Worksheet 1 cost center where the expense is to be reported. Expenses grouped and reported as "other" or "miscellaneous" must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 2: Covered Dental Health Costs

Line 28 – Dentists
Costs incurred for dentists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 29 – Dental Hygienists
Costs incurred for dental hygienists who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 30 – Dental Assistants
Costs incurred for dental assistants who are furnishing direct health care services to patients, including those who are employed by the FQHC as well as those who work as independent contractors.

Line 31 – Dental Laboratory and Supplies
Costs incurred for the in-house dental laboratory services, excluding dentures and partial dentures,

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

Line 32 – Pharmaceuticals Incident to a Dental Service
Costs for pharmaceuticals that are used incident to a provided dental service.

Line 33 – Dental Movable Equipment
Costs for the purchase of small equipment utilized to deliver clinical dental services to patients under the Federal capitalization threshold of $5,000.

Additionally, the cost of movable dental equipment, including rental and depreciation of dental equipment, is reported in this cost center. Dental equipment allowed in this cost center is limited to movable equipment used to provide dental services, treatments, and diagnostics to patients. Examples include x-ray machines, beds, autoclaves, defibrillators, and wheelchairs. If the FQHC is able to identify interest expense associated with specific assets in this cost center (such as a capital lease), the interest expense may also be included in this cost center. However, allocations of interest expense are not allowed in this cost center if the FQHC is unable to tie interest expense to a specific asset with third party documentation.

Furniture and décor, including those located in exam rooms, are not considered dental equipment and may not be included in this cost center. No fixed equipment may be included. Additionally, software and computer equipment are not included in this cost center.

Line 34 – Dental Equipment Repairs & Maintenance
Costs for minor repairs and maintenance to equipment utilized to deliver clinical services to patients.

Line 35 – Other Dental Health
This cost center is to be used to report any other dental health covered health care costs that do not fit on Lines 28 through 34, and do not have another Worksheet 1 cost center where the expense is to be reported. Expenses grouped and reported as "other" or "miscellaneous" must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 3: Covered Specialty Behavioral Health Costs
Costs reported in this section should reflect the cost for services (procedure codes) included in the Colorado Behavioral Health Capitation as RAE covered services and Short Term Behavioral Health services in the primary care setting benefit. The procedure codes that define a specialty behavioral health service are detailed on page 4 of these instructions. The costs, such as staff time, for all other behavioral health procedure codes as well as non-encounter based behavioral health services are reported in the Covered Physical Health Costs section of Worksheet 1.

Line 36 – Psychiatrists
Costs incurred for psychiatrists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 37 – Licensed Clinical Psychologists
Costs incurred for licensed clinical psychologists who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 38 – Licensed Clinical Social Workers
Costs incurred for licensed clinical social workers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors.

Line 39 – Other Licensed Behavioral Health Providers
Costs incurred for other licensed behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors. This includes licensed marriage and family therapists, licensed professional counselors, licensed addiction counselors, psychiatric social workers, psychiatric nurse practitioners, family therapists, and other licensed Master's Degree-prepared clinicians.

Line 40 – Other Behavioral Health Providers
Costs incurred for other behavioral health providers who are furnishing direct health care services to patients, including those employed by the FQHC as well as those who work as independent contractors. This includes unlicensed individuals and "certified" individuals who provide counseling, or support to behavioral health providers, as well as interns, residents, or candidates for licensure in any of the professions identified in lines 36 through 39.

Line 41 – Other Specialty Behavioral Health
Any other behavioral health capitation and short-term behavioral health services benefit covered health care costs that do not fit on Lines 36 through 40 are reported in this line, if they do not have another Worksheet 1 cost center where the expense is to be reported. Expenses grouped and reported as "other" or "miscellaneous" must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 4: Non-Reimbursable Patient Service Costs
These costs are incurred to provide:

1. Medicaid-covered services that are reimbursed outside of the FQHC cost report; and

2. Services that are not reimbursed under Colorado's Medicaid State Plan Amendment, are not in the FQHC's scope of project, or do not meet the Medicare definition of FQHC services.

Line 42 – Pharmacy
An FQHC that operates its own pharmacy that serves Medicaid patients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number. In this case, because pharmacy costs are paid to the FQHC via a dispensing fee, all direct costs related to the pharmacy must be reported in Worksheet 1, Section A, Subsection 4. Direct costs related to a pharmacy that does not serve Medicaid patients should also be reported in this section.

According to the Colorado Medicaid Provider Bulletin dated October 2014, providers that participate

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

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

Because 340B program contracts are not applicable to Medicaid patients, the costs of these programs, up to the amount of revenue generated, must be reported on Line 42 of the cost report and receive an allocation of the FQHC's overhead expense. Costs of this type of 340B program include the cost of the drugs purchased, fees incurred and paid to the contracted company to administer the program, and any other costs specifically incurred for the contracted program.

Pharmacy costs (retail and 340B) must receive an allocation of the FQHC's overhead expenses. Pharmacy overhead costs are allocated through the Pharmacy Overhead Allocation Form, unless the FQHC allocates all types of overhead costs directly to the Pharmacy at the invoice level or chooses to let overhead be allocated to Pharmacy through the cost report. Use of the direct allocation method or the cost report allocation should be noted and attested to on the Pharmacy Overhead Allocation Form. Overhead costs identified on the Pharmacy Overhead Allocation form are then removed from the Pharmacy line.

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

- Revenue generated = $200,000
- Cost of drugs = $70,000
- Fees paid to Capture Rx = $80,000
- Revenue in excess of expense = $50,000
- The FQHC must report the cost of drugs and the fees paid to Capture Rx ($70,000 and $80,000, respectively) on Line 42 the cost report

Line 43 – LARC Devices

Costs incurred for LARC devices. Costs incurred for the insertion or removal of LARC devices should be included in Section A: Direct Patient Care Costs, Subsection 1 Covered Physical Health Costs. This line should total $0 in column 9.

Line 44 – Inpatient Hospital
Costs incurred by the FQHC to provide services in an inpatient hospital setting and on-call costs related to inpatient services. If applicable, on-call inpatient hospital costs may be identified using an appropriate cost allocation methodology. This line should total $0 in column 9.

Line 45 – Dentures and Partial Dentures
Costs incurred by the FQHC to provide dentures and partial dentures to patients. This includes costs for staff time, contracted work, lab work, supplies, etc. These costs must receive an allocation of overhead expenses.

Line 46 – Dental Services Provided in an Outpatient Hospital Setting
Costs incurred by the FQHC to provide dental services in an outpatient hospital setting. This line should total $0 in column 9.

Line 47 – Prenatal Plus Program
Costs incurred through a separate contract with the State of Colorado for the Prenatal Plus Program. The Prenatal Plus Program is a special program for pregnant women on Health First Colorado (Colorado's Medicaid Program) who qualify. Prenatal Plus involves a team of providers working together to help reduce the chances of low birth weight. This line should total $0 in column 9.

Line 48 – Nurse Home Visitor Program
Costs incurred through a separate contract with the State of Colorado for the Nurse Home Visitor Program (NHVP). NHVP is a program for qualifying women who are pregnant with their first child. The program is also for these first children up to their second birthday. NHVP offers case management and health education services to moms and their first babies in order to help them get the medical and social services they need. This line should total $0 in column 9.

Line 49 – Offsite Laboratory/X-Ray/Specialty Care Office Visits
Costs paid by the FQHC for laboratory, radiology, specialty care, etc. are non-reimbursable as these visits are typically billed to Medicaid by the provider of the service. If the FQHC can demonstrate through contract with the off-site laboratory that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with that service should be included in Section A: Direct Patient Care Costs. This line should total $0 in column 9.

Line 50 – Antagonist Injections for Substance Use Disorder
The cost incurred for antagonist injections for the treatment of substance use disorders, such as Vivitrol. This line should total $0 in column 9.

Line 51 – COVID-19 Vaccine Administration
Costs incurred for the administration of COVID-19 vaccines, as calculated on Addendum 4. This line should total $0 in column 9.

Line 52 – COVID-19 Monoclonal Antibody Infusion
Costs incurred for the provision of monoclonal antibody therapy treatments for COVID-19. These costs must receive an allocation of overhead expenses.

Line 53 – COVID-19 Antiviral Medication (Remdesivir)
Costs incurred for the provision of COVID-19 antiviral medication (Remdesivir). These costs must

receive an allocation of overhead expenses.

Line 54 – Other Patient Services Not Covered by Colorado Medicaid
Costs incurred by the FQHC to provide services not covered by Colorado Medicaid. Examples of these services can be found in the *Worksheet 1 – Reclassification and Adjustment of Trial Balance of Expenses* section of this document.

Line 55 – Movable Equipment for Non-Reimbursable Services
Costs for the purchase of small equipment utilized to deliver clinical services to patients under the Federal capitalization threshold of $5,000, associated with non-reimbursable services.

Costs of movable equipment, including rental and depreciation of medical equipment are reported in this cost center, if applicable. Equipment in this cost center is limited to movable equipment used to provide non-reimbursable health care services, treatments, and diagnostics to patients. If the FQHC is able to identify interest expense associated with specific assets in this cost center (such as a capital lease), the interest expense may also be included in this cost center. However, allocations of interest expense are not allowed in this cost center if the FQHC is unable to tie interest expense to a specific asset with third party documentation.

Furniture and décor, including those located in exam rooms, are not considered medical equipment and may not be included in this cost center. No fixed equipment may be included. Additionally, software and computer equipment are not included in this cost center. Do not offset costs reported in this cost center, as it is required for these costs to receive an allocation of overhead (as they do for direct patient care cost centers).

Line 56 – Other Non-Reimbursable Patient Service
This line is used to report costs for any other direct patient service costs reimbursed outside of the cost report. Expenses grouped and reported as “other” or “miscellaneous” must be detailed on a separate schedule and supporting documentation must be maintained.

Line 57 – Total Direct Patient Care Costs
Total of all costs in Section A.

Section B: General Service Costs
This section includes costs that are not reported within Section A: Direct Patient Care Costs, as they are more general in nature. The expenses in Section B are divided into three subsections:

Subsection 1: Costs Allocated to All Patient Services
Subsection 2: Non-Reimbursable Administrative Costs
Subsection 3: Overhead Costs

Subsection 1: Costs Allocated to All Patient Services
Some health care costs are not directly applicable to one specific rate. These costs are included in this section and will be allocated appropriately across direct patient care costs. If an FQHC is able to directly allocate costs to a specific service category (physical health, dental health, specialty behavioral health, or non-reimbursable), Department approval is required during the cost report audit process for direct allocations of costs otherwise categorized in Section B, Subsection 1. Approval will be based on whether

the FQHC can demonstrate that a direct allocation is more accurate. The FQHC will also need to demonstrate that direct allocation takes into consideration the costs in Subsection 4: Non-Reimbursable Patient Service Costs. This provision is in place to avoid direct allocation as a means to materially increase reimbursement in a manner that is inconsistent across FQHCs. If an FQHC believes they meet the criteria for direct assignment of Section B, Subsection 1 costs, the FQHC must report the costs initially in the applicable Section B, Subsection 1 cost center, then use Worksheet 1 Supplement 1 to reclassify the expense in column 6. The auditor will review the allocation and ask for a supporting narrative for the allocation. Remaining costs will be allocated on Worksheet 2.

Line 58 – Medical Records

Costs incurred for time spent by staff directly on patient medical records. Costs for staff that perform medical records tasks in addition to other clerical tasks must be split between covered health care costs and overhead. Costs associated other clerical tasks (not medical records) are reported in Section B: Subsection 3, Overhead Costs of Worksheet 1.

Line 59 – Electronic Health Records

Costs incurred to purchase (including depreciation/amortization) or lease electronic health records (EHR) software, and hardware used exclusively for EHR. This includes software licensing fees, interface modules, upgrades, and maintenance fees for the EHR software.

Additionally, costs incurred for EHR staff and consultants may be reported in this line if performing maintenance on the EHR system. If EHR staff/consultants have both EHR and other IT duties, only the portion of staff costs for time spent performing maintenance of the EHR system should be reported in Line 59. Staff time spent using the EHR system for purposes other than direct patient care or maintaining the EHR system are not included in this cost center (e.g. reporting, financial analytics, etc.). Documentation in support of staff time allocated between EHR and IT must be documented and maintained for review.

All other IT related costs are reported in Line 77, IT, including mixed-use hardware and non-EHR maintenance IT staff cost.

Line 60 – Malpractice – Providers

Costs incurred for the portion of malpractice insurance relative to the providers reported in the direct patient care section and not to administrative staff. The providers of most FQHCs are covered for malpractice through the Federal Tort Claims Act (FTCA) and there is no cost to the FQHC. However, some FQHCs carry gap policies that cover providers, which may be reported in this cost center.

Line 61 – Translation

Costs incurred for translation services that are incurred for direct patient care (e.g. during a visit) and are reasonable in amount. The cost of multilingual call center/reception staff or administration staff are reported in their respective cost centers.

Line 62 – Patient Transportation

Costs incurred for transporting patients, as well as covered health care staff travel costs that are incurred to see a patient and provide direct care. Unless incurred to see a patient, other staff travel costs are reported in Line 93, Travel and Transportation. Staff travel expense must be reasonable in amount to be included as allowable expense on Worksheet 1.

Line 63 – Case Management
Costs incurred for the delivery of case management services directly to patients. Include patient navigation in this cost center.

Line 64 – Call Center/Reception
Costs incurred for call center/reception staff dedicated to activities related to providing customer care services in person, electronically or over the phone to patients. This includes activities such as:

1. Entering data for patients into an electronic medical record
2. Contacting patients over the phone or processing paperwork in-person to collect information about the patient's past treatments and other historical medical data, including medications and surgical history
3. Answering patient questions about billing, payments, eligibility, etc.
4. Screening incoming calls to provide the proper routing to other departments when necessary
5. Registering, scheduling and re-scheduling patients for initial appointments and follow-ups

Line 65 – Quality Improvement and Compliance
Costs incurred for the health center's Quality and Compliance staff and projects, including all personnel who are dedicated to activities related to these programs. Includes costs of personnel dedicated to Quality Improvement projects, corporate compliance, system development and analysis, and contracted services.

Line 66 – Billing and Coding
Costs incurred for billing and coding staff. This includes activities such as coding, collections, education and training, etc.

Line 67 – Biohazardous Waste
Costs incurred for the proper disposal of waste that has the risk of carrying infectious diseases, such as blood and blood products, contaminated personal protective equipment, IV tubing, and needles.

Line 68 – Outstationing
Costs associated with outstationing activities provided to patients, such as salary, fringe benefits, travel, training, and maintenance of equipment. The costs in this line are not limited to Medicaid-only outstationing costs.

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

Line 69 – Other Costs Allocated to All Patient Services
This line is used to report any other direct health care costs which require allocation across all patient

service costs. Expenses grouped and reported as "other" or "miscellaneous" must be detailed on a separate schedule and supporting documentation must be maintained.

Subsection 2: Non-Reimbursable Administrative Costs

Line 70 – Marketing
Costs of unallowable advertising and staff that perform marketing functions. These costs must receive an allocation of overhead expenses. Allowable advertising and public relations costs are reported in Section B, Subsection 3: Overhead Costs. All advertising, marketing, development, public relations, and related costs not defined as allowable in Section B, Subsection 3: Overhead Costs must reported on this line of the cost report. These include, but are not limited to:

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

Line 71 – Unallowable Outreach
Costs incurred to perform outreach services into the general community. These costs must receive an allocation of overhead expenses.

Line 72 – Fundraising
Costs of fundraising and staff that perform fundraising functions. These costs must receive an allocation of the FQHC's overhead expenses.

Line 73 – Grant Writing
Costs of grant writing and staff that perform grant writing functions. These costs must receive an allocation of overhead expenses.

Line 74 – Other
Costs of unallowable administrative costs not reported in other lines of Section B, Subsection 2.

Subsection 3: Overhead Costs
All remaining costs should be reported in Subsection 3: Overhead Costs. Overhead costs will be allocated across covered and non-reimbursable costs on Worksheet 1. Non-reimbursable pharmacy overhead costs will be allocated using the Pharmacy Overhead Allocation Form.

Line 75 – Administration
Costs incurred for administrative staff such as the chief executive officer, the executive director, administrative assistants, secretaries, business managers, clinic managers, front desk supervisors, office technicians, special projects staff, medical office managers, and any other staff that do not participate in the direct delivery of health care products and services but are necessary for operation of the FQHC.

Administrative time of provider staff (chief medical officer, medical director, and assistant medical director) should be included in this cost center and will most likely be reclassified from Section A: Direct Patient Care Costs.

Other costs reportable in this cost center include the following:

- Board of Directors – stipends, mileage, meetings, retreats
- Contract services for administrative projects – interim administrative staff, etc.
- Dues and subscriptions for the company – not specific to a provider contract
- Printing – brochures, patient handbooks, forms, etc.
- License fees for the company or administrative staff

Interest costs, with the exception of mortgage interest and interest for specific items reported in movable equipment cost centers, are reported in this cost center. This would include interest incurred on lines of credit, financing of equipment, etc.

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

Line 76 – Finance
Costs incurred for financial staff, such as the chief financial officer, finance director, controller, assistant controller, accountants, accounting technicians, accounts payable clerks, and payroll clerks. Other costs reportable in this cost center include the following:

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

Line 77 – Information Technology (IT)
Costs incurred for information technology staff including the director, assistant director, coordinator, programmers, technicians, computer operators, etc. Also includes other IT costs such as software and hardware upgrades and maintenance agreements. Refer to the Line 59 description for specific EHR costs reported outside of Line 77. Any IT costs not specifically referenced in Line 59 are reported in the IT cost center.

Line 78 – Human Resources
Costs incurred for human resources employees responsible for recruiting, screening, interviewing, and placing workers in addition to managing employee relations, benefits, and training. Additionally, recruitment costs for administrative staff; costs incurred for recruitment of staff reported in Section A: Direct Patient Care Costs can be reported in that section.

Line 79 – Legal
Costs incurred for legal services. This includes all legal costs including attorney fees, court costs, out-of-court settlements, etc.

Line 80 – Housekeeping
Costs incurred for janitorial staff or contracted labor, as well as janitorial supplies.

Line 81 – Security
Costs incurred for security staff, non-depreciable security systems (cost of $5,000 or less) and security

monitoring fees.

Line 82 – Supplies and Equipment
Costs incurred for administrative supplies used in clinics, office supplies, postage, books, accounting supplies, etc. Additionally, non-clinical and office equipment purchased at a cost under the Federal capitalization threshold of $5,000 is reported here.

Line 83 – Insurance
Costs incurred for insurance including the following:

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

The cost of provider malpractice insurance is reported in Section B, Subsection 1 Costs Allocated to All Patient Services, and the cost of clinic malpractice insurance is reported in Line 84.

Line 84 – Malpractice – Clinic
Costs incurred for the purchase of malpractice insurance for non-providers and other costs such as deductibles and co-payments. The cost of provider malpractice insurance is reported in Section B, Subsection 1.

Line 85 – Allowable Advertising, Outreach and Public Relations
Costs incurred for allowable advertising, outreach and public relations. The only advertising costs allowable on the cost report are:

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

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

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

Line 86 – Telephone
Costs incurred for telephone expense (landlines, cell phones, pagers, answering service) as well as for phone system leases.

Line 87 – Utilities
Costs incurred for utilities for the FQHC facilities including heat, electricity, etc.

Line 88 –Maintenance/Repair
Costs incurred for maintenance or repair of administrative facilities and equipment, as well as the cost of waste disposal. Biohazardous waste disposal is reported in Line 67. All other trash and waste disposal costs are reported in this cost center.

Line 89 – Rent
Costs incurred for rental of facilities, equipment, vehicles, and any other type of rental or lease costs. Expense recorded for donated rent must be adjusted out in Column 8.

Line 90 – Depreciation
Expense recorded for depreciation of the capitalized cost of non-medical equipment, furniture, office equipment, computer equipment, buildings, vehicles, etc. The FQHC must be the recorded titleholder of the equipment and the assets must be identifiable and recorded in the accounting records in accordance with Generally Accepted Accounting Principles. Refer to the instructions for Lines 24, 33, and 55 for a description of specific capitalized medical and dental movable equipment that may be reported in these lines. All other allowable depreciation expense is reported in this cost center.

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

Line 91 – Amortization
Expense recorded for amortization of the capitalized cost of items such as bond costs, loan costs, etc.

Line 92 – Contributions
Costs incurred for contributions to other entities including both those directly related to the provision of health care and those that are not directly related to the provision of health care.

Line 93 – Travel and Transportation
Costs incurred by all staff for travel and transportation costs, except patient transportation, are reported in this cost center. (Note: Patient transportation costs are reported in Line 62.) Include costs for messenger service, mileage, medical records transportation, lodging and meals (when applicable), and any other travel and transportation costs.

Line 94 – Mortgage Interest
Costs incurred for real estate mortgage interest. This line is only for interest paid on facility debt. All other interest (lines of credit, equipment loans, etc.) is to be reported in the Administration cost center or as allowed in Movable Equipment cost centers. Interest income will be adjusted out in Column 8 up to the amount of interest expense.

Line 95 – Property Tax
Costs incurred for property tax on property used in the FQHC operation.

Line 96 – Other Overhead
This line is used to report any other overhead costs that do not fit on other cost centers in Section B, Subsection 3. Expenses grouped and reported as "other" or "miscellaneous" must be detailed on a separate schedule and supporting documentation must be maintained.

Line 97 – Total Overhead Costs
Total of all costs on Lines 75 through 96.

Line 98 – Total General Service Costs
Total of all costs in Section B.

Section C: Total Costs
Total of Section A and Section B (sum of Lines 57 and 98).

WORKSHEET 1 – SUPPLEMENT 1

Reclassifications

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

All reclassifications are entered on this form. After the reclassifications have been entered, the total of Columns 4 and 7 (which should agree to each other) are summed on Line 44. The reclassification entries are automatically transferred to the applicable lines on Worksheet 1, Column 6.

Examples of costs that require reclassification are as follows:

1. **Administrative and Health Care Services Duties**

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

2. **Services Provided in the FQHC and Hospital**

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

Columns of Worksheet 1 – Supplement 1

Column 1 – Explanation of Entry
This column is used to describe the nature of the reclassification, such as "physician administrative time" or "physician inpatient time."

Column 2 – W/S 1 Cost Center
This column identifies the section of Worksheet 1 that will be increased by the reclassification.

Column 3 – To W/S 1 Line Number
This column identifies the line number relative to the cost center in Column 2 that will be increased by the reclassification. Enter only a single line number in each cell.

Column 4 – Amount (Positive Num.)
This column identifies the amount by which the line in Column 3 will be increased. Enter the increase as a positive number.

Column 5 – W/S 1 Cost Center
This column identifies the section of Worksheet 1 that will be decreased by the reclassification.

Column 6 – From W/S 1 Line Number
This column identifies the line number relative to the line in Column 6 that will be decreased by the reclassification. Enter only a single line number in each cell.

Column 7 – Amount (Negative Num.)
This column identifies the amount by which the line in Column 6 will be decreased. Enter the decrease as a negative number.

WORKSHEET 1 – SUPPLEMENT 2

Adjustments to Expenses

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

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

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

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

Columns of Worksheet 1 – Supplement 2

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

Column 1 – W/S 1 Cost Center
This column identifies the cost center on Worksheet 1 that is being adjusted.

Column 2 – W/S 1 Line Number
This column identifies the line number on Worksheet 1 that is being adjusted. Enter only a single line number in each cell.

Column 3 – Amount
This column identifies the dollar amount of the cost adjustment. A positive number increases expense on Worksheet 1; a negative number decreases expense on Worksheet 1.

Lines of Worksheet 1 – Supplement 2

Line 1 – Pharmacy
Pharmacy services are reimbursed outside of the FQHC cost report.

Line 2 – LARC Devices
LARC devices are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 3 – Inpatient Hospital
Services provided in an inpatient setting are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 4 – Dental – Outpatient Hospital
Dental services provided in an outpatient hospital setting are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 5 – Prenatal Plus Program
The Prenatal Plus Program is reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 6 – Nurse Home Visitor Program
The Nurse Home Visitor Program is reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 7 – Offsite Lab/X-Ray/Specialty
Patient visits for laboratory, radiology, and specialty care are typically billed to Medicaid by the provider of the service. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8. However, if the FQHC can demonstrate through contract with the off-site laboratory, radiology, or specialty care clinic that only the FQHC is billed for services rendered, and not third-party payers, the costs associated with those services should be included in Worksheet 1, Section A.

Line 8 – Antagonist Injections for Substance Use Disorder
Antagonist Injections for Substance Use Disorder are reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 9 – COVID-19 Vaccine Administration
COVID-19 Vaccine Administration is reimbursed outside of the FQHC cost report. As the reimbursement does not include overhead, all costs must be adjusted off in Column 8.

Line 10 – Other Patient Services Not Covered by Colorado Medicaid
Other patient services not covered by Colorado Medicaid may require an adjustment in Column 8, if there is no overhead cost associated with the services.

Line 11 – ACC PMPM Revenue
FQHCs that participate with one of Colorado Medicaid's Accountable Care Collaboratives (ACC) are paid a per member per month (PMPM) fee for each patient enrolled in the ACC. This line is used for the offset of ACC PMPM revenue calculated according to the policy reflected in the instructions for Addendum 5. Addendum 5 of the cost report is used to calculate the appropriate ACC PMPM offset. Refer to the Instructions section on Addendum 5 for additional information.

Line 12 – Medicaid Grants
Revenue received as part of a Medicaid grant for Medicaid client services must be adjusted off in Column 8 to prevent duplicative payment by the Medicaid program.

Line 13 – Lobbying
Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable. The amount of the adjustment reported should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 14 – Bad Debt
Bad debt expense is unallowable and must be adjusted off.

Line 15 – In-Kind/Donated Costs
The costs of in-kind services or donations received by the FQHC (e.g. rent, supplies, equipment, staff time, etc.) are unallowable and must be adjusted off. However, costs associated with maintaining donated equipment are allowable and should remain in Worksheet 1.

Line 16 – Miscellaneous Income
Some types of miscellaneous income must be offset against expense. Miscellaneous income is defined as income not directly related to patient care and includes items such as expense rebates, medical records copy fees, etc. The amount of the adjustment should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 17 – Interest Income
Interest income must be offset against interest expense, up to the amount of interest expense. The amount of the adjustment should agree to the amount reported on Addendum 2 – Unallowable Expenses.

Line 18 – Lease Income
Lease income must be adjusted out of the cost report and should be offset against facility costs.

Lines 19-44 – Other (Specify)
There are a number of blank lines on Worksheet 1 – Supplement 2 – Adjustments to Expenses for reporting of other adjustments specific to each FQHC.

Line 45 – Total Adjustments
This is the total amount of all adjustments entered in Column 3 – Amount. Adjustments entered on Worksheet 1 – Supplement 2, are automatically transferred Column 8 (Adjustments) of Worksheet 1.

WORKSHEET 2

Allocation of Expenses

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

Part A – Allocation of Patient Service Overhead Costs

Line 1 Total covered physical health costs from Worksheet 1, Column 9, sum of Lines 1 through 27.

Line 2 Total covered dental health costs from Worksheet 1, Column 9, sum of Lines 28 through 35.

Line 3 Total covered specialty behavioral health costs from Worksheet 1, Column 9, sum of Lines 36 through 41.

Line 4 Total directly attributed non-reimbursable patient service costs from Worksheet 1, Column 9, sum of Lines 42 through 55.

Line 5 Total directly attributed patient care costs. Sum of Lines 1 through 4.

Line 6 Calculates the percentage of directly attributed covered physical health costs. Line 1 divided by Line 5.

Line 7 Calculates the percentage of directly attributed covered dental health costs. Line 2 divided by Line 5.

Line 8 Calculates the percentage of directly attributed covered specialty behavioral health costs. Line 3 divided by Line 5.

Line 9 Calculates the percentage of directly attributed non-allowable patient service costs. Line 4 divided by Line 5.

Line 10 Total costs to be allocated to all patient services from Worksheet 1, Column 9, sum of Lines 57 through 68.

Line 11 Calculates the costs to be allocated to the Physical Health Rate. Line 6 multiplied by Line 10.

Line 12 Calculates the costs to be allocated to the Dental Health Rate. Line 7 multiplied by Line 10.

Line 13 Calculates the costs to be allocated to the Specialty Behavioral Health Rate. Line 8 multiplied by Line 10.

Line 14 Calculates the costs to be allocated to non-reimbursable patient services. Line 9 multiplied by Line 10.

Line 15 Calculates the total covered health care costs for the Physical Health Rate. The sum of Line 1 and Line 11.

Line 16 Calculates the total covered health care costs for the Dental Health Rate. The sum of Line 2 and Line 12.

Line 17 Calculates the total covered health care costs for the Specialty Behavioral Health Rate. The sum of Line 3 and Line 13.

Part B-Allocation of Overhead Costs

Line 18 Total covered health care costs for the Physical Health Rate from Line 15 above.

Line 19 Total covered health care costs for the Dental Health Rate from Line 16 above.

Line 20 Total covered health care costs for the Specialty Behavioral Health Rate from Line 17 above.

Line 21 Total non-reimbursable costs. Sum of Line 4 and Line 14 above, plus Worksheet 1, column 9, Lines 69 through 73.

Line 22 Calculates the total of all costs excluding overhead costs. The sum of Line 18 through Line 21.

Line 23 Calculates the percentage of total covered physical health costs as a portion of all costs excluding overhead. Line 18 divided by Line 22.

Line 24 Calculates the percentage of total covered dental health costs as a portion of all costs excluding overhead. Line 19 divided by Line 22.

Line 25 Calculates the percentage of total covered specialty behavioral health costs as a portion of all costs excluding overhead. Line 20 divided by Line 22.

Line 26 Total overhead costs from Worksheet 1, Column 9, Lines 74 through 95.

Line 27 Calculates the overhead costs that are applicable to the Physical Health Rate. Line 23 multiplied by Line 26.

Line 28 Calculates the overhead costs that are applicable to the Dental Health Rate. Line 24 multiplied by Line 26.

Line 29 Calculates the overhead costs that are applicable to the Specialty Behavioral Health Rate. Line 25 multiplied by Line 26.

Line 30 Calculates the total costs for the Physical Health Rate. The sum of Line 18 and Line 27.

Line 31 Calculates the total costs for the Dental Health Rate. The sum of Line 19 and Line 28.

Line 32 Calculates the total costs for the Specialty Behavioral Health Rate. The sum of Line 20 and Line 29.

Line 33 Calculates the combined costs for the Physical Health, Dental Health, and Specialty Behavioral Health services (i.e. the combined cost of FQHC services). The sum of Lines 30 through 32. These will be the costs incorporated into the FQHC's All-Inclusive Rate.

WORKSHEET 3

FQHC Provider Staff, Visits and Productivity

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

Part A – FQHC Provider Staff and Visits

Columns of Part A – FQHC Provider Staff and Visits

Columns 1-4
These columns calculate the total number of FTEs based on the FQHC's normal hours for full-time employment. Note that 2,080 is the maximum number of paid hours to be considered full-time. The FTE for providers is the time spent seeing patients or scheduled to see patients and does not include administrative time, per the Medicare Benefit Policy Manual, Chapter 13. Beginning March 1, 2020, the FTE for providers also includes time spent providing telehealth or telemedicine services to patients. For providers who deliver health care services on an inpatient basis (hospital rounds), only the FTE relative to the delivery of outpatient services should be reported. The FTE relative to the inpatient services is not reported as these services are reimbursed to the FQHC on a fee-for-service basis rather than through the FQHC encounter rate.

Column 1 – FTE Personnel – Contract
This column identifies the total number of FTEs contracted by the FQHC.

Column 2 – FTE Personnel – Volunteer
This column identifies the total number of FTEs that work on a volunteer basis at the FQHC.

Column 3 – FTE Personnel – Staff
This column identifies the total number of FTEs that are employed and paid by the FQHC.

Column 4 – FTE Personnel – Total
This column calculates the total number of FTEs for each provider category.

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

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

Columns 5-7
These columns identify the visits by provider type. A visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife,

visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor.

Group sessions do not generate a billable encounter for any FQHC services[6], and do not meet the definition of a visit.

A distinct specialty behavioral health visit is generated when the rendered services (procedure codes) are included in the six sessions of Short Term Behavioral Health (STBH) services reimbursed directly by the Department or the services are covered by a contracted Regional Accountable Entity (RAE). Regardless of payer or billing status, the following procedure codes are specialty behavioral health services:

- Short Term Behavioral Health services: 90791, 90832, 90834, 90837, 90846, 90847.
- Services covered by the RAE: 00104, 90785, 90849, 90853, 90875, 90876, 90887, 96116, 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139, 96372, 96535, 97537, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, G0176, G0177, H0006, H0015, H0017, H0018, H0019, H0020, H0033, H0034, H0035, H0036, H0037, H0038, H0039, H0040, H0043, H0044, H0045, H2001, H2012, H2014, H2015, H2016, H2017, H2018, H2021, H2022, H2023, H2024, H2025, H2026, H2027, H2030, H2031, H2032, H2033, S3005, S5150, S5151, S9445, S9480, S9485, T1005, and T1017.

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

Column 5 – Visits – On-Site
This column identifies the total number of visits delivered at a clinic site operated by the FQHC directly.

Column 6 – Visits – Off-Site
This column identifies the total number of visits delivered to FQHC clients at a site not directly operated by the FQHC, such as a nursing facility.

Column 7 – Total Visits
This column calculates the total number of visits for each provider category.

Lines of Part A – FQHC Provider Staff and Visits
The lines of Worksheet 3 identify the providers approved by the State of Colorado for which FTE and visits data is presented. Only those providers approved by the State of Colorado per 10 CCR 2505-10 8.700 (physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor, and behavioral health masters

[6] 10 CCR 2505-10 8.700.1

level candidates for licensure) are to be reported on Worksheet 3.

Lines 1-3
These lines identify the FTEs and visits for medical providers (physicians, physician assistants, nurse practitioners, and certified nurse midwives) included in the physical health rate. These subtotals will be used in the productivity standard calculations in Part B of Worksheet 3.

Lines 4-9
These lines identify the FTEs and visits for other providers included in the physical health rate. If applicable, the FTE and visits associated with interns and residents are reported in Line 9 – Other.

Lines 10-11
These lines identify the FTEs and visits for dental health providers included in the dental health rate.

Lines 12-14
These lines identify the FTEs and visits for behavioral health providers included in the specialty behavioral health rate.

Line 15
Calculates the total FTEs and visits.

Part B – Minimum Medical Team Productivity

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

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

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

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

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

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

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

Exception to Productivity Standards
Productivity standards established by the State of Colorado are guidelines that reflect the total combined services of the staff. If the FQHC does not meet the productivity standards, an exception may be granted

based upon specific circumstances. Examples of reasons for not meeting the productivity standards include the following: newly designated FQHC entities, newly established FQHC sites, new FQHC provider staff with low volume, an FQHC that provides the majority of services to special populations, implementation of an electronic medical record, etc.

Part C – Provider Visits for Rate Determination

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

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

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

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

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

WORKSHEET 4

Determination of FQHC Encounter Rates

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

Part A – All-Inclusive Rate

Line 1 The combined costs for the Physical Health, Dental Health, and Specialty Behavioral Health Rate services (i.e. the combined cost of FQHC services) from Worksheet 2, Line 33.

Line 2 The combined provider visits for the rate determination from Worksheet 3, Line 23.

Line 3 Calculates the uninflated Current Year Calculated All-Inclusive Rate. Line 1 divided by Line 2.

Line 4 Calculates the FQHC inflation factor. Line 3 multiplied by the applicable MEI.

Line 5 Calculates the Current Year Calculated Inflated All-Inclusive Rate. The sum of Line 3 and Line 4.

Line 6 Current Year Inflated All-Inclusive Base Rate (entered by the Department's contractor).

Line 7 Calculates the Alternative Payment Methodology All-Inclusive Rate. The lower of Line 5 and Line 6.

Line 8 The Inflated PPS Rate (entered by the Department's contractor).

Line 9 Calculates the final All-Inclusive Encounter Rate. The higher of Line 7 and Line 8.

Part B – Physical Health Rate

Line 10 The total costs for the Physical Health Rate from Worksheet 2, Line 30.

Line 11 The total provider visits for the Physical Health Rate determination from Worksheet 3, Line 20.

Line 12 Calculates the uninflated Current Year Calculated Physical Health Rate. Line 10 divided by Line 11.

Line 13 Calculates the FQHC inflation factor. Line 12 multiplied by the applicable MEI.

Line 14 Calculates the Current Year Calculated Inflated Physical Health Rate. The sum of Line 12 and Line 13.

Line 15 The Current Year Inflated Physical Health Base Rate (entered by the Department's contractor).

Line 16 Calculates the Alternative Payment Methodology Physical Health Rate. The lower of Line 14 and Line 15.

Line 17 The Quality Component reduction (entered by the Department's contractor).

Line 18 Calculates the final Physical Health Encounter Rate. Line 16 reduced by Line 17.

Part C – Dental Health Rate

Line 19 The total costs for the Dental Health Rate from Worksheet 2, Line 31.

Line 20 The total provider visits for the Dental Health Rate determination from Worksheet 3, Line 21.

Line 21 Calculates the uninflated Current Year Calculated Dental Health Rate. Line 19 divided by Line 20.

Line 22 Calculates the FQHC inflation factor. Line 21 multiplied by the applicable MEI.

Line 23 Calculates the Current Year Calculated Inflated Dental Health Rate. The sum of Line 21 and Line 22.

Line 24 The Current Year Inflated Dental Health Base Rate (entered by the Department's contractor).

Line 25 Calculates the Alternative Payment Methodology Dental Health Rate. The lower of Line 23 and Line 24.

Line 26 The final Dental Health Encounter Rate. This is Line 25.

Part D – Specialty Behavioral Health Rate

Line 27 The total costs for the Specialty Behavioral Health Rate from Worksheet 2, Line 32.

Line 28 The total provider visits for the Specialty Behavioral Health Rate determination from Worksheet 3, Line 22.

Line 29 Calculates the uninflated Current Year Calculated Specialty Behavioral Health Rate. Line 27 divided by Line 28.

Line 30 Calculates the FQHC inflation factor. Line 29 multiplied by the applicable MEI.

Line 31 Calculates the Current Year Calculated Inflated Specialty Behavioral Health Rate. The sum of Line 29 and Line 30.

Line 32 The Current Year Inflated Specialty Behavioral Health Base Rate (entered by the Department's contractor).

Line 33 Calculates the Alternative Payment Methodology Specialty Behavioral Health Rate. The lower of Line 31 and Line 32.

Line 34 The Quality Component reduction (entered by the Department's contractor).

Line 35 Calculates the final Specialty Behavioral Health Encounter Rate. Line 33 reduced by Line 34.

Part E – Physical Health Payment Per Member Per Month

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

WORKSHEET 5

Revenues

Worksheet 5 is used to report revenues, and must reconcile to the audited financial statements.

Lines of Worksheet 5

Line 1 – Patient Revenues
Revenue received for providing patient services.

Line 2 – Contributions, Donations, Bequests
Revenue received as a contribution, donation, or bequest.

Line 3 – Purchase Discounts
Revenue received as a discount for purchases made.

Line 4 – Rebates and Refunds of Expenses
Revenue received for rebates and refunds of expenses.

Line 5 – Sale of Medical/Nursing Supplies and DME to Other than Patients
Revenue received for the sale of medical and/or nursing supplies and durable medical equipment (DME) to parties other than patients.

Line 6 – Sale of Drugs to Other than Patients
Revenue received for the sale of drugs to parties other than patients.

Line 7 – Sale of Medical Records and Abstracts
Revenue received for the sale of medical records and abstracts.

Line 8 – Government Appropriations
Revenue received from the government on the behalf of Federal, State and/or local government programs.

Line 9 – Grant Revenue – Medicaid
Revenue received from Medicaid grants.

Line 10 – Grant Revenue – Non-Medicaid
Revenue received from non-Medicaid grants.

Line 11 – COVID-19 Public Health Emergency Funding
Revenue received for the COVID-19 public health emergency (PHE), including small business association loan forgiveness.

Line 12 – 340B Contract Revenue
Revenue received under a 340B contract.

Line 13 – ACC PMPM Base Payments for Attributed Members
Base ACC PMPM payments received for Medicaid member months attributed to the FQHC. Should match the amount listed in Addendum 5.

Line 14 – ACC Other Payments
All other ACC payments received by the FQHC, such as PMPM payments for enhanced care coordination services, incentive payments, and other lump sum payments.

Line 15 – Interest Income
Revenue received from interest income.

Line 16 – Rent Income
Revenue received from rental of FQHC property.

Line 17 – Miscellaneous Income
Miscellaneous income generated from services that are not directly related to patient care.

Lines 18-39 – Other (Specify)
Any other revenues received by the FQHC are reported under "Other".

Line 40 – Total
Automatically calculates the total revenue in Line 1 through Line 39.

ADDENDUM 1

Encounter Report

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

Sections of Addendum 1

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

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

Encounter Type
This column identifies the names of the payer.

Column 1 – Medicaid/CHP+ Encounters
This column identifies all Medicaid and CHP+ client encounters that correspond with each payer. These are all claims that are eligible to be paid at the FQHC encounter rates.

Column 2 – Total Encounters
This column identifies the total encounters that correspond with each payer.

A comparison to total dental visits from Worksheet 3 is included for informational purposes. It is not expected that a variance exists.

Physical Health Encounters
This section identifies Physical Health encounters, including Medicaid, HMO, and CHP+ encounters by payer. The columns are completed similarly to that detailed in the Dental Encounters section above. A comparison to total physical health visits from Worksheet 3 is included for informational purposes. It is not expected that a variance exists.

Behavioral Health Encounters
This section identifies all behavioral health encounters.

Lines 22-28
These lines identify the Medicaid and total RAE/STBH encounters. The columns are completed similarly to that detailed in the Dental Encounters section above.

Line 29
This line automatically calculates the total RAE/STBH encounters.

Line 30
This line identifies the Medicaid and total non-RAE/STBH behavioral health encounters.

Line 31
This line automatically calculates the total RAE/STBH and non-RAE/STBH behavioral health encounters.

A comparison to total behavioral health visits from Worksheet 3 is included for informational purposes. It is not expected that a variance exists.

Total Encounter Variance
This section of the form automatically calculates the variance in total encounters between Addendum 1 and Worksheet 3.

Line 34
Automatically calculates the total number of encounters. This should be the same as the total encounters on Worksheet 3, Column 7, Line 15 (which has been carried over to Line 35 here).

Line 36
Automatically calculates the variance between Line 34 and Line 35.

Line 37
Any variances shown on this schedule must be explained in this section.

ADDENDUM 2

Unallowable Expenses

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

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

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

Lines of Addendum 2

Line 1 – Alcoholic Beverages
The cost of alcoholic beverages of any kind are unallowable. This includes social events that may be hosted by the FQHC as well as alcoholic beverages purchased by employees traveling on business.

Line 2 – Lobbying Expense
Costs incurred for lobbying, whether paid as part of organizational dues or paid directly, are unallowable. For example, a portion of the Colorado Community Health Network (Primary Care Association) dues is for lobbying, and is unallowable.

Line 3 – Gifts and Donations
The cost related to the FQHC giving gifts and donations to other entities or people is unallowable. Examples include donations to Local Fun Runs, donations in lieu of flowers, etc. This should align with Line 95 on Worksheet 1.

Line 4 – Volunteers and Donated Services, Goods, or Space
The value of volunteers and donated services is not reimbursable as a cost, regardless of the service donated. The value of any donated goods or space is not reimbursable as a cost.

Line 5 – Sports and Other Tickets
The cost incurred by the FQHC for any type of sporting or other tickets i**s** unallowable.

Line 6 – Other Entertainment
The cost incurred by the FQHC for any other type of entertainment besides sports and other tickets is unallowable.

Line 7 – Country Club Dues
The cost of country club dues paid on behalf of the FQHC or any of its employees is unallowable.

Line 8 – Education Expenses for Spouse or Other Relatives
The costs to pay for educational expenses of spouses or other relatives of the FQHC's employees are unallowable.

Line 9 – Costs Incurred on Behalf of Related Organizations
Any costs incurred on behalf of an organization related to the FQHC are unallowable.

Line 10 – Costs Associated with Reorganizations, Mergers, Acquisitions, etc.
Costs incurred by the FQHC related to reorganizations, mergers, or acquisitions are unallowable.

Line 11 – Cost of Travel Incurred in Connection with Non-patient Care Related Purposes
Travel costs that are not related to patient care are unallowable.

Line 12 – Personal Use of Autos
The cost of personal use of a company vehicle is unallowable. For example, if an employee maintains use of a company vehicle for business and personal use, and is taxed on the personal use at the end of each tax year, the cost related to the personal use must be removed from the cost report as unallowable.

Line 13 – Housing and Personal Living Expenses
Costs of housing, housing allowances, and personal living expenses for any of the FQHC's officers or employees are unallowable.

Line 14 – Patient Incentives
Costs of incentives given to patients for visiting the clinic are unallowable. These include rewards given to children for visiting the pediatric portions of the clinic.

Line 15 – Reach Out and Read Expenses
Costs associated with the program Reach Out and Read, or any such similar program, are unallowable.

Line 16 – Fines and Penalties
Costs associated with fines or penalties of any kind are unallowable.

Line 17 – Miscellaneous Income
Miscellaneous income generated from services that are not directly related to patient care (such as medical records copy fees, etc.) must be offset against the associated expense. Additionally, rebates, refunds and credits must be applied as a reduction to the associated expense.

Line 18 – Interest Income
Interest income earned must be offset against interest expense, up to the amount of interest expense.

Lines 19-30 – Other (Specify)
Any other unallowable costs incurred by the FQHC are reported under "Other" with an explanation of the cost.

Line 31 – Total
Automatically calculates the total unallowable expense reported in Line 1 through Line 30.

ADDENDUM 3

Administration Breakdown

This form provides for a breakdown of the overhead costs reported on Worksheet 1, Line 74 – Administration. All administration costs should be included in as much detail as possible. If any costs are identified in the Administration Breakdown that belong under other lines in the Cost Report, these costs will be moved to the appropriate line.

Columns of Addendum 3

Explanation of Entry
This column contains the description of the cost included in Worksheet 1, Line 74 – Administration.

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

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

Amount
This column identifies the amount included in Worksheet 1**,** Line 74 – Administration for the specific cost.

Lines of Addendum 3

Lines 1 – 100
Each line identifies a specific cost that is included in Worksheet 1, Line 74 – Administration. Use as many lines as needed. If the amount of lines is not adequate for the number of administrative costs, similar costs may be consolidated into one line.

Line 101 – Total Administration
This line automatically calculates the total amount of all administrative costs reported in Column 3 – Amount. The total amount should be equal to Worksheet 1, Line 74, Column 5 - Total.

ADDENDUM 4

COVID-19 Vaccine Administration Calculator

Addendum 4 is used to calculate COVID-19 vaccine administration costs. This Addendum is applicable to FQHCs that provide COVID-19 vaccines. The administration of COVID-19 vaccines is reimbursed at the fee schedule rate, and is therefore carved out from the FQHC APM and PPS rates. This form calculates the total costs that must be reclassified to Worksheet 1, Line 51, and then offset on Line 51 of the FQHC Medicaid Cost Report. Supporting documentation for the amounts entered in this form must be provided upon request.

Note: This is the only acceptable methodology to calculate COVID-19 vaccine administration costs.

Refer to the Instructions section on Addendum 4 for line by line direction for completing the addendum.

ADDENDUM 5

ACC PMPM Offset Calculator

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

Beginning July 1, 2018, these PMPM payments were made by the Regional Accountable Entity (RAE) to the FQHC at a base amount of $2 per patient enrolled in the ACC. Currently, RAEs make attribution payments to the FQHC at varying PMPM amounts described in the RAE contracts with the FQHCs.

The PMPM paid to the FQHC shall not be considered when calculating the per-visit encounter rate provided for in 10 CCR 2505-10 8.700.6. If the FQHC utilizes the funds on allowable costs, costs up to but not exceeding the received PMPM funds must be excluded from the cost report. ACC PMPM revenue subject to offset is determined on a member-specific basis. Meaning, the actual PMPM payments received by the FQHC must be offset on the cost report, unless spent on unallowable costs. If the FQHC received $1 PMPM for some members, and $3 PMPM for other members, the revenue generated from each payment category would be subject to offset. All PMPM payments for attribution to the FQHC are subject to offset (referred to as a base payment or payment for attribution). However, some FQHCs receive a base payment for attribution, plus additional PMPM payments for providing enhanced care coordination services to Medicaid members. While the base payment for member attribution is subject to offset, additional PMPM payments for enhanced care coordination services are not subject to offset.

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

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

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

In order to support the assertion that the FQHC spent the base PMPM on unallowable costs, the FQHC must maintain documentation demonstrating how the accounting system tracks expenditures associated with the base PMPM, versus all other revenue received by the FQHC. In addition, the FQHC must maintain calculations demonstrating how the expenditures associated with the base PMPM were determined. This includes, but is not limited to, identification of specific expenditures by working trial balance account and amount, justification for how each expenditure supports activities and services described in the signed written document (referenced above), as well as calculation(s) apportioning the identified unallowable expenditures between the Medicaid and non-Medicaid populations. *(Note: Assertions will not be accepted that PMPM funds were used to cover services that are billable or funded outside of the FQHC cost report, such as carved out services, due to the availability of funding sources to cover these costs.)*

Addendum 5 is used to calculate the amount of ACC PMPM revenue subject to offset. To complete the addendum, enter PMPM base payment amount received from the RAEs for Medicaid member attribution. The "Base Payment Level" must agree to the FQHC's contract with the RAE. If more than one payment level is applicable during the cost report period, enter each payment level applicable during the cost report period in Column D. For example, an FQHC may receive payments of $1 and $3 as a base payment for different Medicaid members. Both the $1 and $3 PMPM are considered a distinct "Payment Level". In Column E, enter member months applicable to each payment level. Column F automatically calculates revenue by multiplying the payment level by the number of member months associated with each payment level.

APPENDIX A

FQHC Cost Report Forms

All FQHCs must submit an Excel version of the FQHC cost report forms, which may be found here. Documents included in this Appendix are only for reference and are not to be submitted.

COLORADO
Department of Health Care Policy & Financing

COLORADO MEDICAID FEDERALLY QUALIFIED HEALTH CENTER (FQHC) STATISTICAL DATA AND CERTIFICATION FORM

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

1. Cost Report Submission and FQHC Data

Date Submitted:	
Date Received:	
FQHC Name:	
Street:	
City:	
County:	
State:	
Zip Code:	
Phone Number:	
Fax Number:	
Cost Report Contact Name:	
Contact E-mail:	

2. FQHC National Provider Identifier Numbers (continue on tab 2 as necessary)

FQHC Site NPI Number	Corresponding Medicaid ID

3. Reporting Period

Reporting Period Begin:	
Reporting Period End:	

4. Type of Control (Choose one.)

Voluntary Non-Profit:	
Proprietary:	
Government:	
Other:	

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

Clinic or Provider Number	Provider Name, Location

6. Source of Federal Funds (Choose all that apply.)

Community Health Center (Section 330(d), Public Health Service Act):	
Migrant Health Center (Section 329(d), Public Health Service Act):	
Health Services for the Homeless (Section 340(d), Public Health Service Act):	
Other:	

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF CLINIC

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by:

for the cost report period listed above in Item 3 and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the FQHC in accordance with applicable State rules/instructions except as noted:

Signature (Officer or Administrator of FQHC)	
Print Name of Signing Officer or Administrator	
Title	Date

COLORADO MEDICAID FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
STATISTICAL DATA FORM - TAB 2 (If Necessary*)
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

2. (continued from the Statistical Data and Certification Form tab) FQHC NPI Numbers

FQHC Site NPI Number	Corresponding Medicaid ID

* Note: Facilities only need to provide input on this page if the space on the Statistical Data and Certification Form tab was insufficient for Line 2.

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

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

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Cost Center	1. Compensation	2. Fringe Benefits	3. Purchased & Contract Services	4. Other	5. Total (Column 1 through Column 4)	6. Reclassifications (from tab Worksheet 1 Supplement 1)	7. Reclassified Trial Balance (Columns 5+6)	8. Adjustments Increase or (Decrease) (from tab Worksheet 1 Supplement 2)	9. Net Expenses (Columns 7+8)
A. Direct Patient Care Costs									
Subsection 1. Covered Physical Health Costs									
1. Physicians					0	0	0	0	0
2. Physicians Assistants					0	0	0	0	0
3. Nurse Practitioners					0	0	0	0	0
4. Nurse Midwife					0	0	0	0	0
5. Podiatrists					0	0	0	0	0
6. Other Nurses (RN/LPN)					0	0	0	0	0
7. Medical Assistants/Nurse Aides					0	0	0	0	0
8. Interns/Residents					0	0	0	0	0
9. Psychiatrist (Non-RAE/STBH Services)					0	0	0	0	0
10. Licensed Clinical Psychologists (Non-RAE/STBH Services)					0	0	0	0	0
11. Licensed Clinical Social Workers (Non-RAE/STBH Services)					0	0	0	0	0
12. Other Licensed Behavioral Health Providers (Non-RAE/STBH Services)					0	0	0	0	0
13. Other Behavioral Health Providers (Non-RAE/STBH Services)					0	0	0	0	0
14. Laboratory Medical					0	0	0	0	0
15. X-Ray Medical					0	0	0	0	0
16. Physical Therapy					0	0	0	0	0
17. Occupational Therapy					0	0	0	0	0
18. Vocational Therapy					0	0	0	0	0
19. Speech Pathology					0	0	0	0	0
20. Health Education					0	0	0	0	0
21. Medical Supplies					0	0	0	0	0
22. Optometry					0	0	0	0	0
23. Pharmaceuticals Incident to a Medical Service					0	0	0	0	0
24. Medical Movable Equipment					0	0	0	0	0
25. Medical Equipment Repairs & Maintenance					0	0	0	0	0
26. Clinical Pharmacists					0	0	0	0	0
27. Other (Specify):					0	0	0	0	0
Subsection 2. Covered Dental Health Costs									
28. Dentists					0	0	0	0	0
29. Dental Hygienists					0	0	0	0	0
30. Dental Assistants					0	0	0	0	0
31. Dental Laboratory and Supplies					0	0	0	0	0
32. Pharmaceuticals Incident to a Dental Service					0	0	0	0	0
33. Dental Movable Equipment					0	0	0	0	0
34. Dental Equipment Repairs & Maintenance					0	0	0	0	0
35. Other (Specify):					0	0	0	0	0
Subsection 3. Covered Specialty Behavioral Health Costs									
36. Psychiatrists					0	0	0	0	0
37. Licensed Clinical Psychologists					0	0	0	0	0
38. Licensed Clinical Social Workers					0	0	0	0	0
39. Other Licensed Behavioral Health Providers					0	0	0	0	0
40. Other Behavioral Health Providers					0	0	0	0	0
41. Other (Specify):					0	0	0	0	0
Subsection 4. Non-Reimbursable Patient Service Costs									
42. Pharmacy					0	0	0	0	0
43. LARC Devices					0	0	0	0	0
44. Inpatient Hospital					0	0	0	0	0
45. Dentures and Partial Dentures					0	0	0	0	0
46. Dental Services in an Outpatient Hospital Setting					0	0	0	0	0
47. Prenatal Plus Program					0	0	0	0	0
48. Nurse Home Visitor Program					0	0	0	0	0
49. Offsite Laboratory/X-Ray/Specialty Care Office Visi					0	0	0	0	0
50. Antagonist Injections for Substance Use Disorder					0	0	0	0	0
51. COVID-19 Vaccine Administration					0	0	0	0	0
52. COVID-19 Monoclonal Antibody Infusion					0	0	0	0	0
53. COVID-19 Antiviral Medication (Remdesivir)					0	0	0	0	0
54. Other Patient Services Not Covered by Colorado Medicaid					0	0	0	0	0
55. Movable Equipment for Non-Reimbursable Services					0	0	0	0	0
56. Other (Specify):					0	0	0	0	0
57. Total Direct Patient Care Costs (lines 1 through 56)	0	0	0	0	0	0	0	0	0

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

Type of Data: 0

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

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Cost Center	1. Compensation	2. Fringe Benefits	3. Purchased & Contract Services	4. Other	5. Total (Column 1 through Column 4)	6. Reclassifications (from tab Worksheet 1 Supplement 1)	7. Reclassified Trial Balance (Columns 5+6)	8. Adjustments Increase or (Decrease) (from tab Worksheet 1 Supplement 2)	9. Net Expenses (Columns 7+8)
B. General Service Costs									
Subsection 1. Costs Allocated to All Patient Services									
58. Medical Records					0	0	0	0	0
59. Electronic Health Records					0	0	0	0	0
60. Malpractice - Providers					0	0	0	0	0
61. Translation					0	0	0	0	0
62. Patient Transportation					0	0	0	0	0
63. Case Management					0	0	0	0	0
64. Call Center/Reception					0	0	0	0	0
65. Quality Improvement					0	0	0	0	0
66. Billing and Coding					0	0	0	0	0
67. Biohazardous Waste					0	0	0	0	0
68. Outstationing					0	0	0	0	0
69. Other (Specify):					0	0	0	0	0
Subsection 2. Non-Reimbursable Administrative Costs									
70. Marketing					0	0	0	0	0
71. Unallowable Outreach					0	0	0	0	0
72. Fundraising					0	0	0	0	0
73. Grant Writing					0	0	0	0	0
74. Other (Specify):					0	0	0	0	0
Subsection 3. Overhead Costs									
75. Administration					0	0	0	0	0
76. Finance					0	0	0	0	0
77. Information Technology (IT)					0	0	0	0	0
78. Human Resources					0	0	0	0	0
79. Legal					0	0	0	0	0
80. Housekeeping					0	0	0	0	0
81. Security					0	0	0	0	0
82. Supplies and Equipment					0	0	0	0	0
83. Insurance					0	0	0	0	0
84. Malpractice-Clinic					0	0	0	0	0
85. Allowable Advertising, Outreach and Public Relations					0	0	0	0	0
86. Telephone					0	0	0	0	0
87. Utilities					0	0	0	0	0
88. Maintenance/Repair					0	0	0	0	0
89. Rent					0	0	0	0	0
90. Depreciation					0	0	0	0	0
91. Amortization					0	0	0	0	0
92. Contributions					0	0	0	0	0
93. Travel and Transportation					0	0	0	0	0
94. Mortgage Interest					0	0	0	0	0
95. Property Tax					0	0	0	0	0
96. Other (Specify):					0	0	0	0	0
97. Total Overhead Costs (lines 75 through 96)	0	0	0	0	0	0	0	0	0
98. Total General Service Costs (lines 58 through 96)	0	0	0	0	0	0	0	0	0
C. Total Costs (sum of sections A and B)	0	0	0	0	0	0	0	0	0

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

RECLASSIFICATIONS - Worksheet 1, Supplement 1
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Entry Number	1. Explanation of Entry	2. W/S 1 Cost Center	3. To W/S 1 Line Number*	4. Amount (Positive Num.)	5. W/S 1 Cost Center	6. From W/S 1 Line Number*	7. Amount (Negative Num.)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							
26							
27							
28							
29							
30							
31							
32							
33							
34							
35							
36							
37							
38							
39							
40							
41							
42							
43							
44	**Total Reclassifications (sum of column 4 must equal sum of column 7)**			0			0

* Note: Enter line number only. (E.g. Enter 1. Do not enter "line 1".)

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

ADJUSTMENTS TO EXPENSES - Worksheet 1, Supplement 2
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Explanation of Entry	1. W/S 1 Cost Center	2. W/S 1 Line Number*	3. Amount**
1. Pharmacy			
2. LARC Devices			
3. Inpatient Hospital			
4. Dental - Outpatient Hospital			
5. Prenatal Plus Program			
6. Nurse Home Visitor Program			
7. Offsite Lab/X-Ray/Specialty			
8. Antagonist Injections for Substance Use Disorder			
9. COVID-19 Vaccine Administration (Addendum 4)			
10. Other Patient Services Not Covered by Colorado Medicaid			
11. ACC PMPM Revenue (Addendum 5)			
12. Medicaid Grants			
13. Lobbying			
14. Bad Debt			
15. In-Kind/Donated Costs			
16. Miscellaneous Income			
17. Interest Income			
18. Lease Income			
19. Other (Specify):			
20. Other (Specify):			
21. Other (Specify):			
22. Other (Specify):			
23. Other (Specify):			
24. Other (Specify):			
25. Other (Specify):			
26. Other (Specify):			
27. Other (Specify):			
28. Other (Specify):			
29. Other (Specify):			
30. Other (Specify):			
31. Other (Specify):			
32. Other (Specify):			
33. Other (Specify):			
34. Other (Specify):			
35. Other (Specify):			
36. Other (Specify):			
37. Other (Specify):			
38. Other (Specify):			
39. Other (Specify):			
40. Other (Specify):			
41. Other (Specify):			
42. Other (Specify):			
43. Other (Specify):			
44. Other (Specify):			
45. Total Adjustments			**0**
		Total Adjustment per W/S 1	0
		Check Figure Should be Zero	0

* Note: Enter line number only. (E.g. enter 1. Do not enter "line 1".)

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

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

ALLOCATION OF EXPENSES - Worksheet 2
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Note: No facility input necessary on this page.

PART A - ALLOCATION OF PATIENT SERVICE OVERHEAD COSTS

1. Total Covered Health Care Costs Directly Attributed to Physical Health (W/S 1, sum of lines 1 through 27)	0
2. Total Covered Health Care Costs Directly Attributed to Dental Health (W/S 1, sum of lines 28 through 35)	0
3. Total Covered Health Care Costs Directly Attributed to Specialty Behavioral Health (W/S 1, sum of lines 36 through 41)	0
4. Total Directly Attributed Non-Reimbursable Patient Service Costs (W/S 1, sum of lines 42 through 56)	0
5. Total Directly Attributed Patient Care Costs (sum of lines 1 through 4)	0
6. Percentage of Directly Attributed Covered Health Care Costs - Physical Health (line 1 divided by line 5)	#DIV/0!
7. Percentage of Directly Attributed Covered Health Care Costs - Dental Health (line 2 divided by line 5)	#DIV/0!
8. Percentage of Directly Attributed Covered Health Care Costs - Specialty Behavioral Health (line 3 divided by line 5)	#DIV/0!
9. Percentage of Directly Attributed Non-Reimbursable Patient Services (line 4 divided by line 5)	#DIV/0!
10. Total Costs to be Allocated to all Patient Services (W/S 1, sum of lines 58 through 69)	0
11. Costs Allocated to the Physical Health Rate (line 6 multiplied by line 10)	#DIV/0!
12. Costs Allocated to the Dental Health Rate (line 7 multiplied by line 10)	#DIV/0!
13. Costs Allocated to the Specialty Behavioral Health Rate (line 8 multiplied by line 10)	#DIV/0!
14. Costs Allocated to Non-Reimbursable Patient Services (line 9 multiplied by line 10)	#DIV/0!
15. Total Covered Health Care Costs for the Physical Health Rate (sum of line 1 and line 11)	**#DIV/0!**
16. Total Covered Health Care Costs for the Dental Health Rate (sum of line 2 and line 12)	**#DIV/0!**
17. Total Covered Health Care Costs for the Specialty Behavioral Health Rate (sum of line 3 and line 13)	**#DIV/0!**

PART B - ALLOCATION OF OVERHEAD COSTS

18. Total Covered Health Care Costs for the Physical Health Rate (line 15)	#DIV/0!
19. Total Covered Health Care Costs for the Dental Health Rate (line 16)	#DIV/0!
20. Total Covered Health Care Costs for the Specialty Behavioral Health Rate (line 17)	#DIV/0!
21. Total Non-Reimbursable Costs (sum of line 4, line 14, and W/S 1 lines 70 through 74)	#DIV/0!
22. Total of All Costs Excluding Overhead Costs (sum of lines 18 through 21)	#DIV/0!
23. Percentage of Covered Health Care Costs for the Physical Health Rate (line 18 divided by line 22)	#DIV/0!
24. Percentage of Covered Health Care Costs for the Dental Health Rate (line 19 divided by line 22)	#DIV/0!
25. Percentage of Covered Health Care Costs for the Specialty Behavioral Health Rate (line 20 divided by line 22)	#DIV/0!
26. Total Overhead Costs (W/S 1 line 97)	0
27. Overhead Applicable to the Physical Health Rate (line 23 multiplied by line 26)	#DIV/0!
28. Overhead Applicable to the Dental Health Rate (line 24 multiplied by line 26)	#DIV/0!
29. Overhead Applicable to the Specialty Behavioral Health Rate (line 25 multiplied by line 26)	#DIV/0!
30. Total Costs for the Physical Health Rate (sum of line 18 and line 27)	**#DIV/0!**
31. Total Costs for the Dental Health Rate (sum of line 19 and line 28)	**#DIV/0!**
32. Total Costs for the Specialty Behavioral Health Rate (sum of line 20 and line 29)	**#DIV/0!**
33. Combined Costs for Physical Health, Dental Health, and Specialty Behavioral Health Services (sum of lines 30 through 32)	**#DIV/0!**

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

Type of Data:

FQHC PROVIDER STAFF, VISITS AND PRODUCTIVITY - Worksheet 3
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

PART A - FQHC PROVIDER STAFF AND VISITS

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

PART B - MINIMUM MEDICAL TEAM PRODUCTIVITY

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

PART C - PROVIDER VISITS FOR RATE DETERMINATION

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

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

DETERMINATION OF FQHC ENCOUNTER RATES - Worksheet 4

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)
Note: No FQHC input necessary on this page.

PART A - ALL-INCLUSIVE RATE

1. Combined Costs for Physical Health, Dental Health, and Specialty Behavioral Health Services (W/S 2, line 33)	#DIV/0!
2. Combined Provider Visits for Rate Determination (W/S 3, line 23)	0
3. Uninflated Current Year Calculated All-Inclusive Rate (line 1 divided by line 2)	#DIV/0!
4. FQHC Inflation Factor MEI 3.8% [(CMS (CR) #:9348) multiplied by line 3]	#DIV/0!
5. Current Year Calculated Inflated All-Inclusive Rate (sum of line 3 and line 4)	**#DIV/0!**
6. Current Year Inflated All-Inclusive Base Rate	
7. Alternative Payment Methodology All-Inclusive Rate (lesser of line 5 and line 6)	#DIV/0!
8. Inflated PPS Rate	
9. Final All-Inclusive Encounter Rate (higher of line 7 and line 8)	**#DIV/0!**

PART B - PHYSICAL HEALTH RATE

10. Total Costs for the Physical Health Rate (W/S 2, line 30)	#DIV/0!
11. Total Provider Visits for Physical Health Rate Determination (W/S 3, line 20)	0
12. Uninflated Current Year Calculated Physical Health Rate (line 10 divided by line 11)	#DIV/0!
13. FQHC Inflation Factor MEI 3.8% [(CMS (CR) #:9348) multiplied by line 12]	#DIV/0!
14. Current Year Calculated Inflated Physical Health Rate (sum of line 12 and line 13)	**#DIV/0!**
15. Current Year Inflated Physical Health Base Rate	
16. Alternative Payment Methodology Physical Health Rate (lesser of line 14 and line 15)	#DIV/0!
17. Quality Component Reduction	
18. Final Physical Health Encounter Rate (line 16 reduced by line 17)	**#DIV/0!**

PART C - DENTAL HEALTH RATE

19. Total Costs for the Dental Health Rate (W/S 2, line 31)	#DIV/0!
20. Total Provider Visits for Dental Health Rate Determination (W/S 3, line 21)	0
21. Uninflated Current Year Calculated Dental Health Rate (line 19 divided by line 20)	#DIV/0!
22. FQHC Inflation Factor MEI 3.8% [(CMS (CR) #:9348) multiplied by line 21]	#DIV/0!
23. Current Year Calculated Inflated Dental Health Rate (sum of line 21 and line 22)	**#DIV/0!**
24. Current Year Inflated Dental Health Base Rate	
25. Alternative Payment Methodology Dental Health Rate (lesser of line 23 and line 24)	#DIV/0!
26. Final Dental Health Encounter Rate (line 25)	**#DIV/0!**

PART D - SPECIALTY BEHAVIORAL HEALTH RATE

27. Total Costs for the Specialty Behavioral Health Rate (W/S 2, line 32)	#DIV/0!
28. Total Provider Visits for Specialty Behavioral Health Rate Determination (W/S 3, line 22)	0
29. Uninflated Current Year Calculated Specialty Behavioral Health Rate (line 27 divided by line 28)	#DIV/0!
30. FQHC Inflation Factor MEI 3.8% [(CMS (CR) #:9348) multiplied by line 29]	#DIV/0!
31. Current Year Calculated Inflated Specialty Behavioral Health Rate (sum of line 29 and line 30)	**#DIV/0!**
32. Current Year Inflated Specialty Behavioral Health Base Rate	
33. Alternative Payment Methodology Specialty Behavioral Health Rate (lesser of line 31 and line 32)	#DIV/0!
34. Quality Component reduction	
35. Final Specialty Behavioral Health Encounter Rate (line 33 reduced by line 34)	**#DIV/0!**

PART E - PHYSICAL HEALTH PAYMENT PER MEMBER PER MONTH

36. Current Year Calculated Inflated Physical Health Rate (line 14)	#DIV/0!
37. Estimated Average Visits Per Year	
38. Final Physical Health Payment Per Member Per Month	**#DIV/0!**

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

REVENUES - Worksheet 5

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Explanation of Entry	Amount	Brief Note (If Any)
1. Patient Revenues		
2. Contributions, Donations, Bequests		
3. Purchase Discounts		
4. Rebates and Refunds of Expenses		
5. Sale of Medical/Nursing Supplies and DME to Other than Patients		
6. Sale of Drugs to Other than Patients		
7. Sale of Medical Records and Abstracts		
8. Government Appropriations		
9. Grant Revenue - Medicaid		
10. Grant Revenue - Non-Medicaid		
11. COVID-19 Public Health Emergency Funding		
12. 340B Contract Revenue		
13. ACC PMPM Base Payments for Attributed Members		
14. ACC Other Payments		
15. Interest Income		
16. Rent Income		
17. Miscellaneous Income		
18. Other (Specify):		
19. Other (Specify):		
20. Other (Specify):		
21. Other (Specify):		
22. Other (Specify):		
23. Other (Specify):		
24. Other (Specify):		
25. Other (Specify):		
26. Other (Specify):		
27. Other (Specify):		
28. Other (Specify):		
29. Other (Specify):		
30. Other (Specify):		
31. Other (Specify):		
32. Other (Specify):		
33. Other (Specify):		
34. Other (Specify):		
35. Other (Specify):		
36. Other (Specify):		
37. Other (Specify):		
38. Other (Specify):		
39. Other (Specify):		
40. Total Revenue	**0**	

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

ENCOUNTER REPORT - Addendum 1
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

TOTAL ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
1. Total Encounters	0	0

DENTAL ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
2.		
3.		
4.		
5.		
6. Total Dental Encounters	0	0
7. Dental Health Encounters from Worksheet 3		0
8. Dental Health Encounter Variance (Check Figure Should be Zero)		0

PHYSICAL HEALTH ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19. Total Physical Health Encounters	0	0
20. Physical Health Encounters from Worksheet		0
21. Physical Health Encounter Variance (Check Figure Should be Zero)		0

BEHAVIORAL HEALTH ENCOUNTERS

Encounter Type	1. Medicaid/CHP+ Encounters	2. Total Encounters
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29. Total STBH/RAE Encounters	0	0
30. Non-STBH/RAE Behavioral Health Encounters		
31. Total Behavioral Health Encounters	0	0
32. Behavioral Health Encounters from Worksheet 3		0
33. Behavioral Health Encounter Variance (Check Figure Should be Zero)		0

TOTAL ENCOUNTER VARIANCE

34. Total Encounters (column 2, line 1)	0
35. Total Encounters (W/S 3: col 7, line 15)	0
36. Variance	0
37. If there is a variance, please explain in the cell below:	

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

UNALLOWABLE EXPENSES - Addendum 2
For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

EXAMPLE OF UNALLOWABLE EXPENSE FOR MEDICAID COST REPORTS

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

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

ADMINISTRATION BREAKDOWN - Addendum 3

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Explanation of Entry	Column	Amount
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
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90.		
91.		
92.		
93.		
94.		
95.		
96.		
97.		
98.		
99.		
100.		
101. Total Administration		**0**
	Total Administration per W/S 1	0
	Check Figure Should be Zero	0

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

COVID-19 VACCINE ADMINISTRATION CALCULATOR - Addendum 4

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Instructions

This form is applicable to Federally Qualified Health Centers (FQHCs) that provide COVID-19 vaccines. The administration of COVID-19 vaccines is reimbursed at the fee schedule rate, and is therefore carved out from the FQHC APM and PPS rates. This form calculates the total costs that must be reclassified to Worksheet 1 line 51, then offset on Line 51 of the FQHC Medicaid Cost Report. Supporting documentation for the amounts entered in this form must be provided upon request.

Note: This is the only acceptable methodology to calculate COVID-19 vaccine administration costs.

Line	*Instructions*
General:	The input fields in the calculation contain yellow fill. All other fields are automatically calculated.
1	Enter the total costs of health care staff from Worksheet 1 for staff that have provided COVID-19 vaccines directly. Staff cost includes salaries, benefits, and compensation for contract employees.
2	Enter the ratio of the estimated percentage of time involved in administering COVID-19 vaccine injections to the total health care staff time for staff included in Line 1. Do not include provider services under agreement in this calculation. Obtain the estimated percentage of time spent from your accounting books and records. For example, the ratio may be calculated as hours spent administering COVID-19 vaccines divided by total hours worked for the staff that administered COVID-19 vaccines.
3	Multiplies the amount on Line 1 by the amount on Line 2
4	Enter the cost of COVID-19 vaccines and the cost of related medical supplies from Worksheet 1. For example, costs related to gloves, exam paper, alcohol swabs, etc., which were used in the administration of COVID-19 vaccines.
5	Sums Line 3 and Line 4 to calculate the total direct cost of COVID-19 vaccine administration. On the FQHC cost report, reclassify this expense to line 51, then fully offset line 51.
6	Enter from your records the number of COVID-19 vaccine injections administered to all patients.
7	Calculates the cost per COVID-19 injection for information purposes.

Calculation

Line	Description	Amount
	COVID-19 Vaccine Cost	
1	Total cost of health care staff that administered COVID-19 vaccines	
2	Ratio of COVID-19 vaccine staff time to total staff time	
3	COVID-19 vaccine health care staff cost (line 1 x line 2)	$ -
4	Vaccines and related medical supplies cost	
5	Direct cost of COVID-19 Vaccine (line 3 + line 4)	$ -
	COVID-19 Cost per Vaccine (For Information Purposes)	
6	Number of COVID-19 vaccine injections (from your records)	
7	Cost per COVID-19 vaccine injection (line 5 / line 6)	#DIV/0!

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

ACC PMPM OFFSET CALCULATOR - Addendum 5

For Cost Report Period Ends from July 1, 2022 through June 30, 2023 (Version 2023-01-01)

Instructions

This form calculates the total PMPM base payments received from the Regional Accountable Entities (RAEs) that must be offset. The amount calculated below should be carried to Worksheet 1 Supplement 2 Line 11 of the FQHC Medicaid Cost Report. The addendum must be completed in accordance with the FQHC Cost Report Instructions for Addendum 5, and the PMPM base payment level must agree to the amount actually received by the FQHC. Supporting documentation for the amounts entered in this form must be provided upon request.

RAE Region	RAE Name	Column D PMPM Base Payment Level	Column E Member Months	Column F Revenue Received
1	Rocky Mountain Health Plans			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Subtotal:	0	$ -
2	Northeast Health Partners			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Subtotal:	0	$ -
3 and 5	Colorado Access			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Subtotal:	0	$ -
4	Heath Colorado Inc.			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Subtotal:	0	$ -
6 and 7	Colorado Community Health Alliance			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
		Subtotal:	0	$ -
GRAND TOTAL ALL RAEs			**0**	**0**

APPENDIX B

Examples of Other Required Forms

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

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

6575 · Accounting, Legal & Consulting	$ 10					
6575.3 · Audit	$ 10	$ 20	C	3	52
6572 · Community Outreach/Education	$ 10		C	4	53
6575.1 · Legal Expense	$ 10		C	3	54
Data Processing Salaries	$ 10		C	1	55
Data Processing Fringe	$ 10		C	2	55
6525.1 · IT Support	$ 10		C	3	55
6527 · Computer System Maintenance	$ 10		C	4	55
6629 · Janitorial	$ 10		C	3	56
6615 · Maintenance Supplies	$ 10		C	4	56
6645 · Repairs & Maintenance	$ 10		C	4	57
6400 · Medical Records	$ 10				
6515 · Office Supplies	$ 10				
6515.5 · Ink & toner	$ 10	$ 30	C	4	59
6535 · Insurance	$ 10				
6635 · Facility Insurance	$ 10	$ 20	C	4	60
6599 · Telephone	$ 10		C	4	61
6617 · Utilities	$ 10		C	4	62
8000 · Depreciation Expense	$ 10		C	4	64
6520 · Travel/Mileage	$ 10				
6520.5 · Travel-Dental	$ 10				
6521 · Meetings	$ 10	$ 30	C	4	67
6690.1 · Property Taxes	$ 10		C	4	70
6525 · Computer Expense	$ 10				
6526 · Computer Equipment & Supplies	$ 10				
6545 · Office Equipment	$ 10	$ 30	C	4	71
6511 · Bank Fees	$ 10				
6622 · Laundry	$ 10				
6690 · Other Facility	$ 10	$ 30	C	4	72
Total Expense per Audit	**$ 840**				

Sample FTE Report

FQHC Name	
FTE Report	
Date	
Department	FTE
Physician	1.00
Physician Assistant	1.00
Nurse	1.00
Medical Assistant	1.00
Dentist	1.00
Hygienist	1.00
Dental Assistant	1.00
Mental Health	1.00
Case Manager	1.00
Eligibility	1.00
Management	1.00
Fiscal & Billing	1.00
IT	1.00
Facility	1.00
Suport Staff	1.00
Other-Detail	1.00
Other-Detail	1.00
Other-Detail	1.00
Total	18.00

APPENDIX C

Pharmacy Overhead Allocation Form

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

APPENDIX D

FQHC Change-in-Scope Process

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

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

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

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

APPENDIX E

Definitions

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

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

Encounter or Billable Visit: effective March 1, 2020, visit means a one-on-one, face-to-face, interactive audio, interactive video, or interactive data communication encounter between a center client and an Eligible Provider.

Group sessions do not generate a billable encounter for any FQHC services.

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

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

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

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