**Section 635.APPENDIX D Instruction Manual for the BCHS Common Reporting Requirements**

FORM APPROVED

OMB NO. 0915-0004

EXPIRES 12/31/82

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  PUBLIC HEALTH SERVICE  Bureau of Community Health Services  Division of Monitoring and Analysis  5600 Fishers Lane  Rockville, Maryland 20857  (301)443-2376  BUREAU OF COMMUNITY HEALTH SERVICES  COMMON REPORTING REQUIREMENTS  FACE SHEET | | | | | | | | | | | | | 1) BCRR Reporting No. | | | | | 2) Check one: | |
|  | | | | | | | | | | | | |  | | | | | Initial Submission  Revision | |
|  | | | | | | | | | | | | | 3) REPORT FOR PERIOD (Check One & Complete Date) | | | | | | |
|  | | | | | | | | | | | | |  | | | January 198\_\_ through June 198\_\_\_ | | | |
|  | | | | | | | | | | | | |  | | | January 198\_\_ through December 198\_\_\_ | | | |
|  | | | | | | | | | | | | |  | | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | | | |
|  | | | | | | | | | | | | | 4) Sponsor/Grantee Name | | | | | | |
| 5) Project Name and Address | | | | | | | | | | | | | 7) Program(s)\* | | | | | | Grant Number |
|  | | | | | | | | | | | | |  | | | | | |  |
|  | | | | | | |  | | |  | | | (a) | | | | | |  |
|  | | | | | | | | | | | | | (b) | | | | | |  |
| 6) Project Name/Address Change | | | | | | | | | | | | | (c) | | | | | |  |
| since last report? | | | | | | | | | Yes  No | | | | (d) | | | | | |  |
| 8) Name of Person Preparing Report | | | | | | | | | | | | | (e) | | | | | |  |
|  | | | | | | | | | | | | | (f) | | | | | |  |
|  | | | | | | | | | | | | | (g) | | | | | |  |
| 9) Area Code and Business Telephone Number of Person Preparing Report | | | | | | | | | | | | | 10) Director (name) | | | | | | Signature & Date |
| 11) | | Check those tables not submitted with this report because they are totally inapplicable for the reason listed: (do not submit blank tables) | | | | | | | | | | | | | | | | | |
|  | | 2-A | | | | Only applies to projects serving migratory and seasonal agricultural workers. | | | | | | 4 | | | Only applies to primary care projects/grantees. | | | | |
|  | | 2-B | | | | Only applies to CH, FP, MH and other projects designed by the Regional Office. | | | | | | 5 | | | Only applies to projects affected by the Primary Care Effectiveness activity. | | | | |
| \*Grantees receiving support from one or more BCHS program will report the identifying code for each program included and the grant number relating to each program (except in free-standing NHSC sites). The codes are as follows: | | | | | | | | | | | | | | | | | | | |
| CH | | | - Community Health Center (includes RHI, | | | | | | | | HC | | | - National Health Service Corps (BHPDS) | | | | | |
|  | | | - UHI & Hospital-Affiliated). | | | | | | | | MH | | | - Migrant Health | | | | | |
| FP | | | - Title X Family Planning | | | | | | | |  | | |  | | | | | |
| 1. | | Submit: | | | | | | | | | | | | | | |  | | |
|  | | a. | | 3 copies to: | | | | the Data Manager | | | | | | | | | | | |
|  | |  | |  | | | | REGIONAL OFFICE | | | | | | | | | | | |
|  | |  | | (unless the Regional Office specifies otherwise) | | | | | | | | | | | | | | | |
|  | | NOTE: | | | Grantees are in violation of Public Health Service policy if they fail to submit reports that are complete, timely, accurate and valid. Grantees are *ineligible to receive continuation support* if they have failed to comply with the submission requirements of the BCRR as established by the Regional Office. | | | | | | | | | | | | | | |
| 2. | | Direct questions to the Regional Data Manager. | | | | | | | | | | | | | | | | | |
| 3. | | Check the appropriate reporting period and enter the terminal digit for the year in space 3 on the FACE SHEET and the upper right corner of each table. | | | | | | | | | | | | | | | | | |
| 4. | | Attach an explanation to any table for which: | | | | | | | | | | | | | | | | | |
|  | | a. | | sampling is used or estimates have been made; and/or | | | | | | | | | | | | | | | |
|  | | b. | | the data is entered inconsistent with the definitions/instructions used in the BCRR Instruction Manual. Contact the Regional Data Manager if non-standard definitions are used. | | | | | | | | | | | | | | | |
| 5. | | When submitting revisions of tables that have already been sent to the Regional Office or submitting for the first time a table which was omitted from a previous submission: | | | | | | | | | | | | | | | | | |
|  | | a. | | Submit only those tables which are being revised (changed) or being submitted for the first time. | | | | | | | | | | | | | | | |
|  | b. | | | Indicate the reporting period for the revised information on both the FACE SHEET and the table(s).  NOTE: The reporting period for the revised information should match the reporting period indicated on the FACE SHEET. Do not include tables with different due dates under one FACE SHEET; | | | | | | | | | | | | | | | |
|  | c. | | | Check the appropriate box (Initial Submission or Revision) on the FACE SHEET and each table revised; | | | | | | | | | | | | | | | |
|  | d. | | | Where a small number of cells are being revised they should be circled to avoid a re-keying of the entire table; | | | | | | | | | | | | | | | |
|  | e. | | | Follow the distribution schedule in 1 above. | | | | | | | | | | | | | | | |
| (REV. 1/82) | | | | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 1: NUMBER OF USERS BY TYPE OF PROVIDER,**

**AGE AND SEX FOR THIS REPORTING PERIOD**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| AGE AND SEX | | | | | USERS\* BY TYPE OF PROVIDER | |
| MEDICAL  (a) | DENTAL  (b) |
| Female: | | | |  |  |  |
| 1) | 0-4 | | | |  |  |
| 2) | 5-9 | | | |  |  |
| 3) | 10-14 | | | |  |  |
| 4) | 15-19 | | | |  |  |
| 5) | 20-34 | | | |  |  |
| 6) | 35-44 | | | |  |  |
| 7) | 45-64 | | | |  |  |
| 8) | 65 and over | | | |  |  |
| 9) | SUBTOTAL | | | |  |  |
|  | (LINES 1 through 8) | | | |  |  |
| Male: | | |  | |  |  |
| 10) | | 0-4 | | |  |  |
| 11) | | 5-9 | | |  |  |
| 12) | | 10-14 | | |  |  |
| 13) | | 15-19 | | |  |  |
| 14) | | 20-34 | | |  |  |
| 15) | | 35-44 | | |  |  |
| 16) | | 45-64 | | |  |  |
| 17) | | 65 and over | | |  |  |
| 18) | | SUBTOTAL | | |  |  |
|  | | (LINES 10 through 17) | | |  |  |
| 19) | | TOTAL | | |  |  |
|  | | (LINES 9 + 18) | | |  |  |

\*A user is an individual who has had one or more encounters during the reporting period covered by this table (January - June or January - December).

FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 2-A: UTILIZATION OF SPECIAL POPULATION GROUPS**

**FOR THIS REPORTING PERIOD**

NOTE: This table applies to any grantee servicing migratory and/or seasonal agricultural workers and their family members.

|  |  |  |  |
| --- | --- | --- | --- |
| TYPE OF USER | | MEDICAL  USERS\*  (a) | DENTAL  USERS\*  (b) |
| 1) | Migratory Agricultural Workers and Family Members |  |  |
| 2) | Seasonal Agricultural Workers and Family Members |  |  |

\*A user is an individual who has had one or more encounters during the reporting period covered by this table (January - June or January - December).

FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31).

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| BCCR REPORTING NO. |  |  | | REPORT FOR PERIOD (Check One & Complete Date) | | | | | |
|  | | January 198\_\_ through June 198\_\_\_ | | | |
|  | | January 198\_\_ through December 198\_\_\_ | | | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | | | |
| □ Initial Submission | | | □ Revision | |
| FP/FS Delegate? | | | | □ Yes | | □ No |

**TABLE 2-B: NUMBER OF FAMILY PLANNING USERS BY TYPE OF USER AND AGE FOR THIS REPORTING PERIOD**

NOTE: This table applies only to CH, FP, MH, and all other projects required by the Regional Office to report this table. Grantees which are required to submit this table but do no receive Title X funding should report all female Family Planning Users, regardless of income, on LINE 1.

|  |  |  |
| --- | --- | --- |
| TYPE OF FAMILY PLANNING USER | | FAMILY PLANNING USERS\*  (a) |
| 1) | Women at or below 150% of Poverty Level |  |
| 2) | Women above 150% of Poverty Level |  |
| 3) | Men |  |
| 4) | TOTAL (LINES 1+2) |  |
| Female Adolescent Users of Family Planning Services (Subset of LINE 4) | |  |
| 5) | Under 20 years old |  |
| 6) | 15-19 Year Olds |  |

\*A Family Planning user is an individual who has had one or more Family Planning Encounters (Medical or Other Health) during the reporting period covered by this table (January - June or January - December).

FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| BCCR REPORTING NO. | |  | |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
| HCFA I.D. NO. | |  | |  | |  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 3: PERSONNEL BY FUNCTIONAL COST CENTER AND ENCOUNTERS BY TYPE OF PROVIDER FOR THIS REPORTING PERIOD**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PERSONNEL BY FUNCTIONAL COST CENTER\* | | | | | STAFF\* PERSONNEL EQUIVALENTS | | ENCOUNTERS | |
| Onsite With Staff Providers | All Other (Including Offsite  and Nonstaff) |
| (a)\*\* | (b)\*\*\* | (c) | (d) |
| MEDICAL SERVICES | | | (A) | 1) Primary Care Physicians |  |  |  |  |
| 2) Psychiatrists |  |  |  |  |
| 3) Other Medical/Surgical Specialists |  |  |  |  |
| 4) Midlevel Practitioners |  |  |  |  |
| 5) Nurses − Medical |  |  |  |  |
| 6) Medical Support |  |  |  |  |
| ANCIL-  LARY  SERVICES | | | (B) | 7) Laboratory-Medical |  |  |  |  |
| (C) | 8) X-Ray-Medical |  |  |  |  |
| (D) | 9) Pharmacy-Medical & Dental |  |  |  |  |
| DENTAL SERVICES | | |  | 10) Dentists |  |  |  |  |
| (E) | 11) Dental Hygienists/  Oral Therapists |  |  |  |  |
|  | 12) Dental Support |  |  |  |  |
| OTHER  HEALTH  SERVICES | | (G) | | 13) Education/Social Service |  |  |  |  |
| 14) Other Health |  |  |  |  |
| 15) |  |  |  |  |
| 16) Other Health Support |  |  |  |  |
| SUPPORT  SERVICES | | (H) | | 17) Community Service |  |  |  |  |
| (I) | | 18) Environmental Health |  |  |  |  |
| (J) | | 19) Patient Transportation |  |  |  |  |
|  | | 20) Patient Records |  |  |  |  |
| CLINIC  OVER-  HEAD | | (K) | | 21) Administration |  |  |  |  |
| (L) | | 22) Facility |  |  |  |  |
|  | | | | 23) TOTAL (LINES 1 through 22) |  |  |  |  |
| \* | Assign staff time by function performed, not title. See instructions for this table. | | | | | | | |
| \*\* | Include only NHSC personnel in Column (a). | | | | | | | |
| \*\*\* | Include salaried personnel, as well as the personnel equivalents of any non-salaried personnel (contractual or donated) who work for the grantee on a scheduled time basis. (See definition of "Staff.") Include WIC, VISTA and volunteer staff, where appropriate. | | | | | | | |
| FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31). | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 4: HOSPITAL INPATIENT CARE BY TYPE OF**

**ENCOUNTER FOR THIS REPORTING PERIOD**

NOTE: To be completed by all primary care grantees/projects. Primary care grantees/projects include: CH, HC, and MH.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| TYPE OF SERVICE | | | | PATIENT ADMISSIONS BY PROJECT STAFF  (a) | HOSPITAL INPATIENT ENCOUNTERS  BY PROJECT STAFF\*  (b) |
| 1) | Pediatrics | | |  |  |
| 2) | Internal Medicine | | |  |  |
| 3) | Obstetrics | | |  |  |
|  |  | | |  |  |
| 4) | Other (Specify) | | |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |
|  | |  |  |  |  |

\*Project staff include salaried, contracted or donated medical personnel, i.e., physicians and midlevel practitioners.

FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31).

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 5: SELECTED CLINICAL SERVICES FOR THIS REPORTING PERIOD**

NOTE: Only applies to projects affected by Primary Care Effectiveness activity, as follows: CH, FP, HC and MH.

|  |  |  |  |
| --- | --- | --- | --- |
| Clinical  User Category | | Records Sampled  (a) | Records in Compliance  (b) |
| 1) | Immunization  24-27 months |  |  |
| 2) | Immunization  6 year olds |  |  |
| 3) | Adolescent Family Planning  Counseling (under 20 years) |  |  |
| 4) | Pap Smear Follow-up |  |  |
| 5) | Hypertension Follow-up  (10 years and over) |  |  |
| 6) | Anemia Screening  24-27 months |  |  |

FREQUENCY OF REPORTING: Semi-annually (January 1 - June 30, July 1 - December 31)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. | |  |  | | REPORT FOR PERIOD (Check One & Complete Date) | | | | |
| HCFA I.D. NO. |  | | |  |  | | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | | |
| □ Initial Submission | | | □ Revision |

**TABLE 6: COSTS BEFORE AND AFTER DISTRIBUTION BY FUNCTIONAL COST CENTER FOR THIS REPORTING PERIOD**

NOTE: Grantees should complete this table as follows:

Annual: The entire table (LINES 1 through 13, COLS. a through g).

First six months (unless instructed by the Regional Office to report quarterly for the first three quarters): Complete all of LINE 13, and the applicable cells of COLS. (f) and (g).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| FUNCTIONAL  COST CENTER | | SALARIED PERSONNEL\* (WORKSHEET A, COL. h) |  | OTHER (INCLUDING CONSULTANT AND CONTRACT SERVICES) | VALUE OF DONATED MATERIAL & SERVICE\*\* | TOTAL BEFORE DISTRIBUTION (COLS.  a + b + c + d) | TOTAL AFTER DISTRIBUTION OF FACILITY COSTS \*\*\* (WORKSHEET B, COL. e) | TOTAL AFTER FINAL DIST. OF CLINIC OVERHEAD COSTS (WORKSHEET B, COL. h) |
| (a) | (c) | (d) | (e) | (f) | (g) |
| HEALTH CARE FUNCTIONS | |  |  |  |  |  |  |  |
| 1) | Medical (A) |  |  |  |  |  |  |  |
| 2) | Laboratory-Medical (B) |  |  |  |  |  |  |  |
| 3) | X-Ray Medical (C) |  |  |  |  |  |  |  |
| 4) | Pharmacy-Medical & Dental (D) |  |  |  |  |  |  |  |
| 5) | Dental (inc. Lab & X-Ray) (E) |  |  |  |  |  |  |  |
| 6) | Inpatient (F) |  |  |  |  |  |  |  |
| 7) | Other Health (G) |  |  |  |  |  |  |  |
| 8) | Community Service (H) |  |  |  |  |  |  |  |
| 9) | Environment (I) |  |  |  |  |  |  |  |
| 10) | Patient Transportation (J) |  |  |  |  |  |  |  |
| CLINIC OVERHEAD FUNCTIONS | |  |  |  |  |  |  |  |
| 11) | Administration (K) |  |  |  |  |  |  | - 0 - |
| 12) | Facility (L) |  |  |  |  |  | - 0 - | - 0 - |
| 13) | TOTAL (LINES 1 though 12) |  |  |  |  |  |  |  |

\*Include the costs of salaried personnel, including the costs of fringe benefits paid to employees (see TABLE 6 Worksheet A).

\*\*Include the costs associated with donated personnel, including NHSC assignees. For NHSC personnel, include the reimbursable cost of the assignee(s), not the amount actually reimbursed to the Corps.

\*\*\*Only the cells not shaded should be completed with the data transferred from Worksheet B.

NOTE: The distribution of PERSONNEL COSTS across from the functional areas should correspond to the distribution of STAFF PERSONNEL EQUIVALENTS shown in TABLE 3. For any individual whose time is split among two or more functions in TABLE 3, the same percentage split should be applied to personnel and consultant costs in this table.

All amounts should be rounded off to the nearest dollar.

CONSISTENCY CHECK:

LINE 13, COL. (e) = LINE 13, COL. (g)

FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31).

**TABLE 6 WORKSHEET A: DISTRIBUTION OF PATIENT RECORDS COSTS**

**AND FRINGE BENEFITS ACROSS FUNCTIONAL COST CENTERS**

NOTE: If this Worksheet is used, it must be retained by the grantee.

It should not be submitted with TABLE 6.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | DISTRIBUTION OF PATIENT RECORDS COSTS | | | | DISTRIBUTION OF FRINGE  BENEFITS COSTS | | | | | Other Costs | Value of  Donated Mat.  & Svcs. | Total Before  Distribution |
| FUNCTIONAL  COST CENTERS | | Number of Encounters | % of Total Encounters | Amount of Personnel Distrb. to Functions | Amount of Other Distrb. to Functions | Salaried Personnel Costs (inc. Col. C) | % of Total Salaries | | Amount of Fringe Benefits Distrb. to Functions | Total Salaried Personnel Costs |
|  | | (a) | (b) | (c) | (d) | (e) | (f) | (g) | | (h) | (i) | (j) | (k) |
| HEALTH CARE FUNCTIONS | |  |  |  |  |  |  |  | |  |  |  |  |
| 1) | Medical (A) |  |  |  |  |  |  |  | |  |  |  |  |
| 2) | Laboratory-Medical (B) |  |  |  |  |  |  |  | |  |  |  |  |
| 3) | X-Ray - Medical (C) |  |  |  |  |  |  |  | |  |  |  |  |
| 4) | Pharmacy-Medical & Dental (D) |  |  |  |  |  |  |  | |  |  |  |  |
| 5) | Dental (Lab & X-Ray) (E) |  |  |  |  |  |  |  | |  |  |  |  |
| 6) | Inpatient (F) |  |  |  |  |  |  |  | |  |  |  |  |
| 7) | Other Health (G) |  |  |  |  |  |  |  | |  |  |  |  |
| 8) | Community Service (H) |  |  |  |  |  |  |  | |  |  |  |  |
| 9) | Environmental (I) |  |  |  |  |  |  |  | |  |  |  |  |
| 10) | Patient Transportation (J) |  |  |  |  |  |  |  | |  |  |  |  |
| 11) | Patient Records |  |  | ( ) | ( ) |  |  |  | |  |  |  |  |
| CLINIC OVERHEAD FUNCTIONS: | |  |  |  |  |  |  |  | |  |  |  |  |
| 12) | Administration (K) |
| 13) | Facility (L) |  |  |  |  |  |  |  | |  |  |  |  |
| 14) | Fringe Benefits |  |  |  |  |  |  | ( ) | |  |  |  |  |
| 15) | TOTAL (LINES 1 though 14) |  | 100% | -0- | -0- |  | 100% | -0- | |  |  |  |  |

**TABLE 6 WORKSHEET B:**

**DISTRIBUTION OF CLINIC OVERHEAD COSTS ACROSS HEALTH CARE COST CENTERS**

NOTE: If this Worksheet is used, it must be retained by the grantee. It should not be

submitted with TABLE 6.

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | Total before Distribution  Worksheet A, Col (k) | DISTRIBUTION OF FACILITY COSTS | | | Total after Distrb. of Facility Costs  (a + d) | DISTRIBUTION OF ADMINISTRATION COSTS | | | Total after Final Distrb.  of Clinic Overhead Costs  (e + g) |
| FUNCTIONAL COST CENTERS | | | Square Feet  of Space Used | % of Square  Footage | Amount of Facility Distrb. to Functions | % of Health Care Cost Subtotal | | Amount of Admin. Distrb. to Functions |
|  | | | (a) | (b) | (c) | (d) | (e) | (f) | | (g) | (h) |
| HEALTH CARE FUNCTIONS | | |  |  |  |  |  |  | |  |  |
| 1) | Medical (A) | |  |  |  |  |  |  | |  |  |
| 2) | Laboratory -- Medical (B) | |  |  |  |  |  |  | |  |  |
| 3) | X-Ray -- Medical (C) | |  |  |  |  |  |  | |  |  |
| 4) | Pharmacy-Medical & Dental (D) | |  |  |  |  |  |  | |  |  |
| 5) | Dental (Lab & X-Ray) (E) | |  |  |  |  |  |  | |  |  |
| 6) | Inpatient (F) | |  |  |  |  |  |  | |  |  |
| 7) | Other Health (G) | |  |  |  |  |  |  | |  |  |
| 8) | Community Service (H) | |  |  |  |  |  |  | |  |  |
| 9) | Environmental (I) | |  |  |  |  |  |  | |  |  |
| 10) | Patient Transportation (J) | |  |  |  |  |  |  | |  |  |
| 11) | SUBTOTAL (LINES 1 through 10) | |  |  |  |  |  | 100% | |  |  |
| CLINIC OVERHEAD FUNCTIONS: | | |  |  |  |  |  |  | | ( ) | -0- |
| 12) | Administration (K) | |
| 13) | Facility (L) | |  |  |  | ( ) | -0- |  | |  | -0- |
| 14) | SUBTOTAL (LINES 12 + 13) | |  |  |  |  |  |  | |  |  |
| 15) | GRAND TOTAL | |  |  | 100% | -0- |  |  | | -0- |  |
|  | | CONSISTENCY CHECKS:  1. COL. (a) equals TABLE 6: COL. (e)  2. COL. (e) equals TABLE 6: COL. (f)  3. COL. (h) equals TABLE 6: COL. (g)  4. LINE 15, COL. (a), COL. (e), COL. (h) should all be equal. | | | | | | |  | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCRR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 7: ACCOUNTS RECEIVABLE, CHARGES AND COLLECTIONS**

**BY SOURCE OF FUNDS FOR THIS REPORTING PERIOD**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| SOURCE OF FUNDS | | | ACCOUNTS RECEIVABLE AT BEGINNING OF THIS PERIOD | | FULL CHARGES AND PREMIUMS DURING THIS PERIOD\* | AMOUNT COLLECTED DURING THIS PERIOD | | | ADJUSTMENTS (identify below)\*\* | | ACCOUNTS RECEIVABLE AT END OF THIS PERIOD |
|  | | | (a) | | (b) | (c) | | | (d) | | (e) |
| 1) Medicare  (Title XVIII) | | |  | |  |  | | |  | |  |
| 2) Medicaid  (Title XIX) | | |  | |  |  | | |  | |  |
| 3) Title XX | | |  | |  |  | | |  | |  |
| 4) Other Third Parties | | |  | |  |  | | |  | |  |
| 5) Patient Fees/Premiums | | |  | |  |  | | |  | |  |
| 6) TOTAL (LINES  1+2+3+4+5) | | |  | |  |  | | |  | |  |
| \*Charges or premiums prior to adjustments for patients' ability to pay, third party disallowances, etc. If Full Charges/Premiums are based upon a negotiated or contractual arrangement with a third party payor, and are not generally reflective of the costs of operation, footnote and explain below (name of third party, per unit, service, or capitation reimbursement rate or dollar limit).  \*\*Breakdown of Adjustments by Type | | | | | | | | | | | |
| DESCRIPTION | | | | | | AMOUNT | | | | | |
| 7) Disallowances and Reductions (Contractual Allowances) | | | | | | $ |  | |  | |
| 8) Sliding Payment Scale Adjustments | | | | | | $ |  | |  | |
| 9) Bad Debt Write Off | | | | | | $ |  | |  | |
| 10) Other (Specify) | | |  | | | $ |  | |  | |
| CONSISTENCY CHECKS: | | | | | | | | | | |
| 1. COL. (e) should equal COL. (a) + COL. (b) – COL. (c) – COL. (d) | | | | | | | | | |
| 2. The amount entered in COL. (a) should equal the amount entered in COL. (e) of the TABLE 7 for the preceding calendar year. | | | | | | | | | |
| When TABLE 7 is completed for the same reporting period as TABLE 8, then: | | | | | | | | | |
| 3. LINE 6, COL. (c) should equal TABLE 8: LINE 16 COL. (a). | | | | | | | | | |
| FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period. | | | | | | | | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| BCCR REPORTING NO. |  |  | REPORT FOR PERIOD (Check One & Complete Date) | | | |
|  | | January 198\_\_ through June 198\_\_\_ | |
|  | | January 198\_\_ through December 198\_\_\_ | |
|  | | \_\_\_\_\_ 198\_\_\_ through \_\_\_\_\_ 198\_\_\_ | |
| □ Initial Submission | | □ Revision |

**TABLE 8: SUMMARY OF RECEIPTS AND EXPENDITURES**

**FOR THIS REPORTING PERIOD**

NOTE: This table applies to grantee receipts and expenditures associated with services or activities in the approved application for BCHS funds, including those associated with delegate agency operations.

Grantees should complete this table as follows:

Annual: The entire table (LINES 1 through 23, COL. a).

First Six Months (unless instructed by the Regional Office to report quarterly for the first three quarters):

LINES 10, 16, 20 and 21 through 23, COL. (a).

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | | Summary of Receipts and Expenditures | | Actual for Reporting Period  (a) |
| Federal Grants | | 1) | Section 329 (Migrant Health) |  |
| 2) | Section 330 (Community Health Center) |  |
| 3) | MCH Block Grants\* |  |
| 4) | Title X (Family Planning)\*\* |  |
| 5) | Section 340 (Primary Care R & D) |  |
| 6) | Appalachian Health |  |
| 7) | Black Lung Clinic Program |  |
| 8) | WIC\*\*\* |  |
| 9) | Other (Specify)\*\*\*\*\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 10) | SUBTOTAL (LINES 1 through 9) |  |
| Payment for  Services | | 11) | Title XVIII (Medicare) |  |
| 12) | Title XIX (Medicaid) |  |
| 13) | Title XX |  |
| 14) | Other Third Parties |  |
| 15) | Patient Collections |  |
| 16) | SUBTOTAL (LINES 11 through 15) |  |
| Other  Sources | | 17) | State |  |
| 18) | Local |  |
| 19) | Other (Specify)\*\*\*\* \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| 20) | SUBTOTAL (LINES 17 through 19) |  |
| Expendi-  tures | | 21) | Capital Expenditures |  |
| 22) | Non-Capital Expenditures\*\*\*\*\* |  |
| 23) | SUBTOTAL (LINES 21 + 22) |  |
| \* | Any form of State assistance through MCH Block | | | |
| \*\* | Indicate Title X funds received directly from the Federal government or indirectly through a delegate agency type relationship on LINE 4. Indicate other Federal grants received directly or indirectly on LINE 9. | | | |
| \*\*\* | Only include monies received for administration and operation of the WIC program, not the monies received for food. Do *not* include money spent on food on LINE 22. | | | |
| \*\*\*\* | Enter NHSC loans on LINE 19. | | | |
| \*\*\*\*\* | Include all actual expenditures by the grantee *and* its delegates on LINE 22. Payments made to the Federal government during the reporting period for the cost of NHSC assignees are entered on LINE 22. | | | |
| FREQUENCY OF REPORTING: Semi-annually unless otherwise instructed by the Regional Office. Data are reported on a calendar year-to-date basis from January first through the ending month of the reporting period (June 30 or December 31). | | | | |

(Source: Added at 14 Ill. Reg. 20783, effective January 1, 1991)