



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF FINANCIAL OPERATIONS
ROOM 525 HEALTH & WELFARE BUILDING
HARRISBURG, PA 17105-2675

MAR 25 2008

KEVIN M. FRIEL
DIRECTOR

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(717) 772-2231
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Ms. Susan M. Post
Executive Director
Esperanza Health Center, Inc.
1331 East Wyoming Avenue
Parkview Hospital, Lower Level MOB
Philadelphia, Pennsylvania 19124-3895

Dear Ms. Post:

I am enclosing the final report of the Esperanza Health Center, Inc., that was completed by this office. Your response has been incorporated into the final report and labeled as Appendix.

I would like to thank you for your patience during the extended delay between the date of the exit conference and the issuance of this final report. The report and its contents were reviewed in detail and discussed at numerous levels within the Department of Welfare prior to this release.

The final report will be forwarded to the Department's Office of Medical Assistance Programs (OMAP) to begin the Department's resolution process concerning the report contents. The staff from OMAP may be in contact with you to follow-up on the action taken to comply with the report's recommendations. It is my understanding that OMAP is agreeable to waiving historical disallowances and to working with you to rebase your rate prospectively.

If you have any questions concerning this matter, please contact Tina Long, Audit Resolution Section, at (717) 705-2288.

Sincerely,

Kevin M. Friel

Enclosures

cc: Mr. Michael P. Nardone
Mr. William Miller
Ms. Brenda Tewell

Mr. Samuel Caramela
Mr. Jeffrey Bechtel



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Mr. Michael P. Nardone
Deputy Secretary
Office of Medical Assistance Programs
Room 515 Health and Welfare Building
P.O. Box 2675
Harrisburg, Pennsylvania 17105

Dear Mr. Nardone:

In response to a request from the Office of Medical Assistance Programs (OMAP), the Bureau of Financial Operations (BFO) performed an audit of the Independent Auditing Firm's application of Agreed Upon Procedures (AUP) to Esperanza Health Center, Inc. (the Provider), a Federally Qualified Health Center (FQHC) who filed Cost Reports for the fiscal years ended March 31, 1999 and 2000. The audit was made in response to a request for a periodic rate review and included in DPW's 2006-2007 Agency Annual Audit Plan. As such, the audit's goal was to determine an encounter rate which includes only allowable program costs.

Based upon the Independent Auditing Firm's application of AUP, an encounter rate of \$141.34 was established effective October 1, 2001. This encounter rate is adjusted annually based on the Medicare Economic Index. As a result of such adjustments, the Provider's encounter rate as of October 1, 2006 is \$162.89. The intention of OMAP is to cost settle the annual encounter rates paid to the adjusted rates determined through audit. As a result, our audit was directed toward developing an encounter rate based on actual allowable costs.

The mission of the BFO, accomplished through audit and review activities, is to assist DPW management to administer human service programs of the highest quality, at the lowest cost, with integrity.

Results In Brief

- The Provider included in its Cost Report the maximum Reasonable Compensation Limits (RCL) for Physicians with adjustments for inflation based on the Consumer Price Index. The additional RCL value was substantially in excess of the compensation paid and therefore, the excess was disallowed. The amounts disallowed were \$461,434 and \$599,751 for the fiscal years ended March 31, 1999, and 2000, respectively (Exhibits A and C).
- Other audit adjustments resulted in a net decrease in allowable insurance costs of \$26,409 and \$9,776 for the fiscal years ended March 31, 1999 and 2000, respectively (Exhibits A and C).
- Collection fees were reduced by \$6,664 for the fiscal year ended March 31, 2000 due to an arithmetic error (Exhibit C).
- Based on actual expenses as audited, per diem rates of \$88.43 and \$104.55 for fiscal years ended March 31, 1999 and 2000, respectively more accurately reflect allowable costs incurred in the provision of FQHA client care (Exhibits B and D).

Background

The Provider is a 501 (c) (3) non-profit corporation located at 1331 East Wyoming Avenue, Philadelphia, Pennsylvania 19124. The agency received its first approved per diem for the fiscal year 1996-97.

The Provider is a community based health care provider in a predominately Latino neighborhood. The Provider is an entry level health clinic with patients who have basic health maintenance needs for treatment of colds and flues, pregnancy, periodic check ups and injuries as well as a diagnostic point for more serious maladies like cancer, heart disease or other chronic conditions. Most of the staff is bilingual and able to interview, treat and counsel patients in their native Spanish.

As addressed in the instructions for preparation of the FQHC Cost Report, in the absence of specific regulations, allowable costs are determined based on the Medicare Provider Reimbursement Manual (HIM-15). In addition, FQHC Cost Report reporting instructions and OMAP policy derived from MA Bulletins may be used to determine allocable costs and procedures.

The Provider submitted Cost Reports for the fiscal years ended March 31, 1999 and March 31, 2000 that were subject to audit by an Independent Certified Public Accounting Firm (IAF). The IAF based its audit on the Provider's adjusted general ledger and made several entries to reclassify and adjust the amounts to conform to its understanding of allowable and reimbursable expenditures.

The BFO met with the IAF, discussed the nature and scope on its work, reviewed its work papers and reviewed the research materials relied upon by the IAF. Based upon

Background (Continued)

recommendations by the Program Office, the BFO concentrated its review on several areas of concern but reviewed all amounts for reasonability of amount and necessity. The BFO accepted the adjustments of the IAF except in two categories, physician compensation and insurance. A third category was found to have an arithmetic error.

Objective/Scope/Methodology

Our review was accomplished by meeting with the Provider's IAF, by analyzing and testing the Provider's expenditures incurred, testing selected transactions, examining underlying records, analyzing the cost allocation process and by making inquiries of the Provider's management. Accordingly, our specific review objective was as follows:

To determine the actual allowable cost of services to FQHC customers and to determine that the underlying expenditures are reasonably consistent with Medical Assistance cost principals and attributable to the Provider.

Government auditing standards require that we obtain an understanding of management controls that are relevant to the audit objective described above. The applicable controls were examined to the extent necessary to provide reasonable assurance of compliance with generally accepted accounting principals. Based on our understanding of the controls, no significant deficiencies came to our attention.

Our audit of the Cost Reports was intermittently conducted between August 15, 2006 and November 13, 2006 and was performed in accordance with the General Instructions for Completion of the Medical Assistance Cost Report. This report, when presented in its final form, will be available for public inspection.

Results of Fieldwork

The Provider and the IAF did not prepare the Cost Reports in accordance with OMAP requirements as detailed in the instructions for FQHC Programs. As a result, certain adjustments were necessary to bring the Cost Reports into compliance.

Issue No. 1 - Physician Compensation Was Disallowed To The Extent It Was Not Paid And Not Reported For Payroll Tax Purposes

The Provider employed five physicians during the audit period. The wages paid to the physicians were reported on the cash basis to the federal, state and local authorities for payroll tax purposes. The BFO reviewed the Pennsylvania Unemployment Tax Returns and was able to reconcile the reported details for each of the eight quarters in the audit period to the cash wages booked in the Provider's general ledger for each fiscal year.

Results Of Fieldwork (Continued)

The Provider retained a consultant who increased the cash basis payroll expense to the RCL for purposes of the Cost Reports. The RCL is a standard, generally used to determine whether or not the compensation paid to key employees is excessive. The RCL standards are commonly used to disallow claims for reimbursements that contain compensation levels in excess of those in the industry or occupation in question. The RCL are commonly used as a ceiling or limit to compensation.

Except for minor adjustments, the IAF allowed the cash payroll to be increased to the RCL amounts despite the fact that the increase was never paid nor reported to any of the federal, state or local taxing authorities as compensation. The Provider's logic was that the customers were receiving the full value of the physicians' services and that the physicians were donating back to the Provider and to the customers the non cash value of the services.

The BFO independently researched this issue to determine whether or not donated services are reimbursable for FQHC Provider purposes by referring to HIM-15 Regulations, Financial Accounting Standards, Professional Journals and the FQHC Provider Handbook.

The BFO determined that donated services pertaining to employed individuals are not reimbursable and informed the Provider of its determination during an audit meeting on November 13, 2006. A summary of the BFO's reasons for this adjustment was delivered to the Provider at this meeting and is included as Exhibit E.

Recommendation

The BFO recommends that the Provider not increase its costs for the value of physicians' services up to the RCL because the costs were never paid during the audit period and because there is no obligation to pay in the future.

Issue No. 2 - Direct And Administrative Insurance Costs Were Overstated Because A Large Part Of The Beginning Prepaid Insurance Balance Was Unsubstantiated

The Provider uses the accrual basis method of accounting. As such, the balance prepaid at the beginning of any given period is expensed as it expires during the fiscal year. At the beginning of the audit period, the prepaid insurance balance was \$35,072. The BFO concluded that, as of April 1, 1998, only \$9,533 of \$35,072 could be substantiated. As a result the expense for the fiscal year ended March 31, 1999 was overstated by a similar amount.

Results Of Fieldwork (Continued)

A separate adjustment was made in each year to more properly allocate insurance expense between direct costs and overhead costs.

Recommendation

The BFO recommends that the Provider maintain a detailed insurance schedule listing each policy, its nature, its total premium and monthly amount, the prepaid amounts for the beginning and end of the period and the annual expense. Such a schedule was prepared by the BFO and given to the provider for the audit period.

Issue No. 3 - Collection Fees Were Miscalculated In 2000

Along with other FQHCs in the vicinity, the Provider had an affiliate who bills the insurance companies for the Provider's services rendered and collects the receivables for a fee. Due to miscalculation, the fee was overstated by \$6,664 for the period January 1, 2000 through March 31, 2000.

Recommendation

The BFO believes that this was a one time error which had no effect on any other periods and is not expected to recur.

Exit Conference/Summation

On March 27, 2007, an exit conference was held. In attendance were representatives from Esperanza Health Center, OMAP, and BFO. At the exit conference it was noted that while Esperanza management does not dispute the BFO insurance cost adjustment, it is for reasons of failure to retain/locate documentation as opposed to reporting an erroneous amount. The balance of discussions pertained to the imputed physicians' salary expense (Issue No. 1). Both parties presented arguments founded in regulations or accounting doctrine. Esperanza cited Generally Accepted Accounting Principles to support their position while the BFO and OMAP used the Provider Reimbursement Manual (HIM-15) regulations as support for the cost adjustments. Bearing upon the Esperanza imputed physicians' HIM-15 is specific in that it does not permit imputed salaries for individuals already remunerated by the entity. As such, the report was issued as final with no revisions. It should be noted that Esperanza petitioned and OMAP agreed to consider all mitigating circumstances pertaining to this issue before making any final decision.

Mr. Michael P. Nardone

-6-

In accordance with our established procedures, please provide a response within 15 days to the Audit Resolution Section concerning actions to be taken to ensure that the report recommendations are implemented.

If you have any questions concerning this matter, please contact Ms. Tina Long, Audit Resolution Section, at (717) 705-2288.

Sincerely,



Kevin M. Friel

Attachments

cc: Mr. William Miller
Ms. Brenda Tewell
Mr. Samuel Caramela
Ms. Susan M. Post
Mr. Jeffrey Bechtel

EXHIBITS

ESPERANZA HEALTH CENTER, INC.
SCHEDULE OF AUDIT ADJUSTMENTS
March 31, 1999

	<u>Per Cost Report</u>	<u>BFO Adjustments</u>	<u>Final Allowable</u>
Core Medical Costs	\$ 868,178	\$ (329,658)	\$ 538,520
Non FQHC Costs	<u>51,015</u>	<u>\$ -</u>	<u>51,015</u>
Total Direct Costs	919,193	(329,658)	589,535
Overhead Costs	<u>709,767</u>	<u>(158,185)</u>	<u>551,582</u>
TOTAL	<u>\$ 1,628,960</u>	<u>\$ (487,843)</u>	<u>\$ 1,141,117</u>
BFO Adjustments:	<u>Insurance</u>	<u>Compensation</u>	<u>Total</u>
Line 1 - Physicians - To reduce to cash wages paid - Allocated 66.5% to Direct Costs		\$ (310,350)	\$ (310,350)
Line 14 - Malpractice Insurance - To reduce unsubstantiated prepaid insurance balance and to reallocate general liability and Officers' and Director's coverage	\$ (19,308)	-	<u>(19,308)</u>
Total Reduction in Direct Costs			<u>\$ (329,658)</u>
Line 60 - Administrative Insurance - To reduce unsubstantiated prepaid insurance balance and to reallocate general liability and Officers' and Directors' coverage	(7,101)		(7,101)
Line 70 - Medical Administration - To reduce to cash wages paid allocated 33.5% to Overhead	<u>-</u>	<u>(151,084)</u>	<u>(151,084)</u>
Total Reduction in Insurance Costs	<u>\$ (26,409)</u>		
Total Reduction in Compensation Costs		<u>\$ (461,434)</u>	
Total Reduction in Overhead Costs			<u>\$ (158,185)</u>

EXHIBIT A

**ESPERANZA HEALTH CENTER, INC.
SCHEDULE OF OVERHEAD APPLICABLE
TO FQHC SERVICE AND
SCHEDULE OF FQHC REIMBURSABLE RATE
March 31, 1999**

FQHC Applicable Overhead

Line 1 - Total Direct FQHC Health Care Cost (Exhibit A)	\$ 538,520
Line 2 - Total All Direct Costs (Exhibit A)	589,535
Line 3 - Percentage of Direct Cost Applicable To FQHC Services (Line 1 ÷ Line 2)	91.35%
Line 4 - Total Overhead Cost (Exhibit A)	551,582
Line 5 - Overhead Cost Applicable to FQHC (Line 3 x Line 4)	503,870

Reimbursable Rate

Line 6 - Total Direct FQHCX Health Care Costs (Line 1)	\$ 538,520
Line 7 - Overhead Cost Applicable to FQHC Service (Line 5)	<u>503,870</u>
Line 8 - Total Cost Applicable to FQHC Services (Line 1 + Line 5)	1,042,390
Line 9 - Total Provider Encounters	11,788
Line 10 - Reimbursable Rate (Line 8 ÷ Line 9)	<u>\$ 88.43</u>

**ESPERANZA HEALTH CENTER, INC.
SCHEDULE OF AUDIT ADJUSTMENTS
March 31, 2000**

	<u>Per Cost Report</u>	<u>BFO Adjustments</u>	<u>Final Allowable</u>	
Core Medical Costs	\$ 1,122,585	\$ (416,416)	\$ 706,169	
Non FQHC Costs	<u>45,543</u>	<u>-</u>	<u>45,543</u>	
Total Direct Costs	1,168,128	(416,416)	751,712	
Overhead Costs	<u>991,070</u>	<u>(199,775)</u>	<u>791,295</u>	
TOTAL	<u>\$ 2,159,198</u>	<u>\$ (616,191)</u>	<u>\$ 1,543,007</u>	
BFO Adjustments:	<u>Insurance</u>	<u>Compensation</u>	<u>CHN Fees</u>	<u>Total</u>
Line 1 - Physicians - To reduce to cash wages paid - Allocated 65.7% to Direct Costs		\$ (394,036)		\$ (394,036)
Line 14 - Malpractice Insurance - To reallocate general liability and Officers' and Directors' coverage	\$ (22,380)			<u>(22,380)</u>
Total Reduction in Direct Costs				<u>\$ (416,416)</u>
Line 60 - Administrative Insurance - To reallocated general liability and Officers' and Directors' coverage	12,604			\$ 12,604
Line 70 - Medical Administration - To reduce to cash wages paid allocated 34.3% to Overhead Costs	-	(205,715)		(205,715)
Line 73 - CHN Network Admin Fees - To correct error	<u>-</u>	<u>-</u>	<u>(6,664)</u>	<u>(6,664)</u>
Total Reduction in Insurance Costs	<u>\$ (9,776)</u>			
Total Reduction in Compensation Costs		<u>\$ (599,751)</u>		
Total Reduction in CHN Collection Fees			<u>\$ (6,664)</u>	
Total Reduction in Overhead Costs				<u>\$ (199,775)</u>

EXHIBIT C

**ESPERANZA HEALTH CENTER, INC.
SCHEDULE OF OVERHEAD APPLICABLE
TO FQHC SERVICE AND
SCHEDULE OF FQHC REIMBURSABLE RATE
March 31, 2000**

FQHC Applicable Overhead

Line 1 - Total Direct FQHC Health Care Cost (Exhibit C)	\$ 706,169
Line 2 - Total All Direct Costs (Exhibit C)	751,712
Line 3 - Percentage of Direct Cost Applicable To FQHC Services (Line 1 ÷ Line 2)	93.94%
Line 4 - Total Overhead Cost (Exhibit C)	791,295
Line 5 - Overhead Cost Applicable to FQHC (Line 3 x Line 4)	743,343

Reimbursable Rate

Line 6 - Total Direct FQHCX Health Care Costs (Line 1)	\$ 706,169
Line 7 - Overhead Cost Applicable to FQHC Service (Line 5)	<u>743,343</u>
Line 8 - Total Cost Applicable to FQHC Services (Line 1 + Line 5)	1,449,512
Line 9 - Total Provider Encounters	13,864
Line 10 - Reimbursable Rate (Line 8 ÷ Line 9)	<u>\$ 104.55</u>

**ESPERANZA HEALTH CENTER
ANALYSIS OF THE AMOUNT OF PHYSICIANS' COMPENSATION
THAT IS REIMBURSABLE
APRIL 1998 TO MARCH 2000**

Question Presented

Should Esperanza Health Center, a Federally Qualified Health Center (FQHC), be allowed to increase its claim for reimbursement for the difference between what was paid to the attending physicians and the Reasonable Compensation Limits (RCL), as modified by the Consumer Price Index (CPI), where the physicians acknowledge working for a below market salary and in effect donate services in an amount equal to the aforementioned difference?

Background

Esperanza is a FQHC located in a lower middle class neighborhood of Philadelphia. Its attending physicians have agreed to provide their professional services at a below market rate.

The Cost Report was subject to certain Agreed Upon Procedures (AUP). In applying the AUPs, the independent accounting firm (IAF) accepted that donated services should be reimbursable. The independent accounting firm allowed a valuation of the physicians' services consistent with the RCL, as modified by the change in CPI from year to year.

Analysis

In allowing Esperanza to claim reimbursement for the value of donated services, the IAF cites as authority Medicare Provider Reimbursement Manual (HIM-15) which, in reference to non-paid workers, states that "...a provider may claim as an allowable cost the value of non-paid workers ...provided that..." certain conditions are met. The conditions are:

- Non paid workers must work more than 20 hours per week in full time positions normally occupied by nonreligious paid personnel. Section 704.1.
- The services must be related directly to patient care or administrative positions that are essential to provision of patient care. Section 704.2.
- Non paid workers must be members of an organization that has made arrangements with the provider for the performance of services by non paid workers. Section 704.5.

**ESPERANZA HEALTH CENTER
ANALYSIS OF THE AMOUNT OF PHYSICIANS' COMPENSATION
THAT IS REIMBURSABLE
APRIL 1998 TO MARCH 2000**

- Reimbursable costs cannot include any imputed value for the services of a worker who has received any direct remuneration from the provider. i.e. non paid workers do not include anyone who receives direct remuneration from the provider. Section 704.6.

On its face, the rationale presented by the IAF does not support Esperanza's position because the physicians were paid and they received their remuneration directly from Esperanza.

The IAF also relies on guidance provided by Generally Accepted Accounting Principles (GAAP) for the recording of professional contributed labor. However, the research provided by the IAF does not include any specific GAAP guidance on donated services.

The Bureau of Financial Operations (BFO) independently researched this issue and found that the provisions of FAS 116 include "contributions of services [that] require specialized skills, are provided by individuals possessing those skills, and would typically need to be purchased if not provided by donation." Services requiring specialized skills are provided by doctors and nurses. As such, according to FAS 116, the value of donated services of physicians would be allowed as a contribution received and as an expense in the year the service was rendered. Additional references are contained in the Appendix to FAS 116.

Although there is an apparent difference between the HIM-15 and FAS, HIM-15 is controlling for purposes of Medicare reimbursement.

Conclusion

The controlling authority on the issue of services donated to a FQHC is HIM-15, otherwise known as the Provider Reimbursement Manual. Pursuant to HIM-15, the value of the services donated by full time paid physicians is not reimbursable because (1) there is no legally enforceable agreement between Esperanza and any organization of non paid physicians which would establish the obligation to remunerate the organization for services rendered (Section 704.5); and, (2) because the physicians receive direct remuneration from Esperanza (Section 704.6).

The BFO would disallow Esperanza's claim for reimbursement of the physicians' donated services and the allowance of same by the IAF.

**AUDITEE'S RESPONSE
APPENDIX**



ESPERANZA HEALTH CENTER

March 16, 2007

Mr. Daniel Higgins, Audit Manager
Division of Audit and Review
Bureau of Financial Operations
Department of Public Welfare
502 Philadelphia State Office Building
1400 Spring Garden Street
Philadelphia, Pennsylvania 19130

Dear Mr. Higgins:

Attached is the response of Esperanza Health Center to the draft performance audit report prepared by the Division of Audit and Review. That report addresses cost reports for the years ended March 31, 1999 and 2000. It is our understanding that our response will be considered in preparation of your final report. We are presenting this to you, as required, ten days prior to the exit conference, which is tentatively scheduled for March 27 in Harrisburg. Thank you for all your work with us and for your consideration of Esperanza's response to your audit. This follows our electronic submission which was forwarded to you earlier today.

We look forward to meeting with you and others on March 17, 2007.

Sincerely,

Susan M. Post, Executive Director

cc: John H. Bungo, CGFM, CFS

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Appendix

Page 1 of 15

**Response of Esperanza Health Center (EHC) to the
Department of Public Welfare (DPW) Audit Exit Meeting
March 27, 2007**

Table of Contents

I	Executive Background Summary	1
II	Summary of Comments and Response	2
III	Background Information	3
IV	Response to Proposed Results of Audit	4
	1. Issue #1 – <u>Basis for Reimbursement of Partially Donated Physician Services</u>	
	2. Issue #1 - <u>If HIM-15 Applies, its Application Supports Reimbursement of Partially Donated Physician Services</u>	
	3. Issue #1 – <u>EHC 's Use of Medical Assistance Funds Consistent with FOHC Purposes and Cost Reimbursement Principles</u>	
	4. Issue #1 – <u>Amount of In-kind Services Provided</u>	
	5. Issue #2 – <u>Insurance Costs</u>	
	6. Issue #3 – <u>Collection Fees</u>	
	7. Miscellaneous Comment on Audit Report	
	8. EHC Conclusion	
V	Response to Result 4 <u>Hardship Imposed by Recommended Retrospective Change in Reimbursement Rates</u>	10
VI	<u>EHC's Request for OMAP's Forbearance</u>	10

Response of Esperanza Health Center (EHC) to the Department of Public Welfare (DPW) Audit Exit Meeting

March 27, 2007

1. Executive Background Summary

Esperanza Health Center (EHC), a faith-based Christian bilingual primary care health center has as its mission to serve the health care needs of the impoverished North Philadelphia Latino community. EHC was established in 1989 by a single physician committed to serving the Spanish-speaking community. Today, EHC's staff of almost 60 employees serves a community of over 125,000 residents. Eight out of the 10 poorest census tracts in Philadelphia are within EHC's service area. In 1992 EHC became a Federally Qualified Health Center (FQHC) "Look-Alike" and in 2006 received its designation as a full FQHC. EHC is also a Ryan White Title III grantee, serving the HIV and at-risk patients of Philadelphia. In its service to the community, EHC strives to provide services of the highest quality and with the utmost integrity. EHC is unique in its commitment to providing bi-lingual services through a clinical staff that speaks Spanish, including each full-time physician. It is Esperanza's privilege to serve the neediest residents of the city of Philadelphia.

In 2001, EHC was required, along with other providers to complete cost reports for 1999 and 2000 to establish base year reimbursement rates. These cost reports were to be analyzed by an Independent Auditing Firm (IAF) applying Agreed Upon Procedures (AUP). EHC's cost report was prepared by Mr. William Tierney, a respected cost accountant who performs cost reports for a significant number of community health centers in PA and reviewed by the IAF Detweiler Hershey & Associates, P.C. who confirmed the cost reports through use of the AUP. These cost reports and AUP report were submitted as required. At that time an encounter rate of \$141.34 was established effective October 1, 2001. This rate, with MEI increases, has been utilized by DPW for the years following, including a cost settlement provided to EHC in 2004, and had been undisputed until recently. The recent audit drafted by the Bureau of Financial Operations (BFO) at the Department of Public Welfare (DPW) contains four results, which are described by issues 1-3 proposing significant disallowances of EHC's costs. EHC disputes issue number one as outlined in the audit and concurs with issues two and three.

EHC pays its physicians less than 50% of the local market rate. They choose to be employed at this compensation rather than accept other professional positions at higher salaries for the opportunity to provide medical care of a longer and more intensive nature required by a poor community with very significant health problems. EHC believes that physician compensation should be viewed as payment to the physician of the market salary rate (or Reasonable Compensation Limits (RCL) rate, if less) with a donation back to EHC of the amount in excess of the salary paid, as required by GAAP accounting rules. DPW believes that Medicare regulation HIM-15, Chapter 7 "Value of Services of Non paid Workers" applies and prohibits this action.

- EHC firmly asserts that Chapter 7 does not apply since it addresses non-paid workers, whereas EHC's physicians are paid. HIM-15 provides that GAAP rules apply in situations it does not address.
- EHC further believes that even if HIM-15, Chapter 7 applies it should be interpreted recognizing it was drafted with a specific type of religious structure in mind, and that reasonable accommodation must be made for other religious groups.

II. Summary of EHC Response and Comments

The findings of this audit, including its disallowances described in issue one and the recommendation of a significant reduction in EHC's reimbursement rate for the years 1999 and 2000, pose a serious threat to the continued service of EHC for the thousands of Latinos in North Philadelphia seeking comprehensive primary care services. EHC's commitments and goals are well-aligned with those of the Commonwealth of Pennsylvania in its desire to provide a community health center program of the highest quality at the lowest cost, with integrity.

As outlined in this response, EHC continues to agree with the conclusions made by its IAF, Detweiler, Hershey & Associates, that EHC's unique situation of such a significant material amount of donated services by paid workers is not accounted for in the HIM-15 regulations (described more fully in the Response to Findings section of this report). Based on the work of EHC's cost accounting consultant, Mr. William Tierney and the IAF, a cost-based reimbursement rate was assigned to EHC for the period beginning October 2001. While being fully aware of EHC's cost-based reimbursement structure, DPW took no action, made no comment, gave no feedback that led EHC to believe it took a wrong course of action by relying on its IAF and the cost accountant in the use of GAAP principles where it believed HIM-15 to not apply. In fact, DPW provided a cost settlement in 2004, years later, for the period 10/1/98 through 09/30/03. While the rate was technically provisional, there was no known indication given to EHC or Mr. William Tierney or the IAF that this methodology was being questioned. This seems to be an inordinately long period of time in which to review these reimbursement rates.

Throughout these years EHC has continued to operate under this reimbursement structure, making strategic plans and decisions based on the needs of the community and the financial viability needed to increase services. EHC has in effect been developing an infrastructure of providing increased health care to the North Philadelphia Latino community. Acting in good faith that it was on the correct legal path and without having received notification that the reimbursement rates were in question, EHC applied for and was awarded a Ryan White Title III grant program, became a full FQHC in 2006 and was awarded section 330 grantee status, added approximately 20 staff members since 2005, opened a satellite location in 2006 and increased patient visits by 50 percent in the past year. In other words, during this time, and in partnership with others, EHC has increased its scope of services significantly, based on these reimbursement rates, with the result of increased access to services for this community.

EHC would like to work with the DPW and its Office of Medical Assistance Programs (OMAP) to determine a mutually acceptable avenue of moving forward to allow EHC to continue to serve and even increase its service to this needy community for years to come.

III. Background Information

EHC is a faith-based Christian bi-lingual primary care health center and FQHC with a mission to serve the health care needs of the North Philadelphia Latino community. EHC currently serves over 4,000 patients at two locations in North Philadelphia, serving primarily the Latino population. As noted above, Esperanza's service area includes 125,000 people, which encompasses eight of the ten poorest census tracts in the city of Philadelphia.

Having started as a small faith-based mission of one physician, EHC has always operated in a manner that acknowledges that the cost of health care provision is often a barrier to meeting the needs of the underserved. During the early years, the personal sacrifice through donated time and services by the medical providers was the only vehicle available to EHC to permit it to reach patients who faced financial barriers in receiving health care services. EHC has continued to attract and retain physicians and professional staff who have a personal "mission" in serving this underserved and vulnerable community. Three of its physicians have each served this community for over twelve (12) years. Because of their personal commitment to such community service, physicians have worked for exceptionally low compensation primarily to allow for available funds to be used from enhanced treatment of patients both in terms of the time spent with patients and the comprehensiveness of evaluation and treatment. In fact, the salaries that physicians received during the audit period ranged from \$40,000 - \$55,000 per FTE, less than half of that of comparable positions in Philadelphia (\$122,800 - \$157,000, which are the 1999 RCL). That difference was voluntarily given up, or in effect *donated* by the employed physicians so that EHC could provide more comprehensive health care to its patients.

The EHC providers have all been trained at esteemed academic centers in the United States, including the University of Pennsylvania, Thomas Jefferson University, Wake Forest University, University of North Carolina, and others. Many graduated at the top of their classes, and the majority attained the highest academic honors. Their backgrounds include such experiences as serving as a chief resident, serving in third world countries, an obtaining an advanced degree in Public Health. All are functionally bilingual and compassionate. Any of EHC's providers could be readily employed in virtually any other clinical or academic setting.

Such enhanced care at EHC takes the form of longer patient visits where complicated multi-faceted medical and human service issues can be addressed with thoroughness. The effectiveness of comprehensive primary care is well documented. HMO comparisons between EHC, other FQHCs and other physician private practices show that EHC patients have a lower hospitalization rate and are seen in the emergency rooms less frequently. Enhanced care has also meant the availability of additional services for patients such as on-site counseling services and assisted by staff social workers who act as advocates for patient's needs that often are not addressed in a medical setting but which directly affect each patient's health.

Since EHC's inception, this physician compensation model which pays considerably less than market salary, has been considered by each committed physician to be the vehicle for providing this enhanced, personal care as EHC and its physicians believe is the best manner in which to provide care. To the physicians, this personal sacrifice is worth it to be able to provide the highest quality health care to those in greatest need. Salaries have been set to a level to provide for the physicians and their families' basic needs such as housing, food and other life necessities.

This commitment by EHC's medical providers goes beyond reduced financial remuneration to the extent that each medical provider commits to attaining a high proficiency in the Spanish language. This bilingual capability is generally accomplished through immersion training programs that the medical providers arrange on their own time and at their own expense. While the extraordinary nature of this commitment is rare, and perhaps even unique in the United States, **the medical providers at EHC have committed their lives to the provision of health care services to the poor in North Philadelphia.**

As a whole, EHC is unique in its commitment to the Spanish speaking constituency of Philadelphia. While other health centers with Spanish-speaking patients make allowances for language barriers, EHC has been committed to eliminating this barrier by providing patients with an entire clinical staff that, with few exceptions, speaks Spanish. This also increases the quality of care by improving communication and decreasing the risk for misdiagnosis and medical errors due to miscommunication with the patient. There is only one other health center in our service area serving these 125,000 people that provides bi-lingual services.

This model of care has produced high quality outcomes for Esperanza's patients. When reviewed by the Medicaid HMOs for quality, EHC consistently scored in the top five percent of health centers overall, and consistently scores below the average of other health centers for emergency room visits and hospital admissions. EHC twice received the GlaxoSmithKline IMPACT Award for excellence in serving the community, and a variety of other awards and citations from the City of Philadelphia. Esperanza has also been a long term member of ECFA (Evangelical Financial Council for Financial Accountability).

Esperanza has been able to obtain and sustain outside funding to help provide medical care to the poor communities of North Philadelphia. In 2001 EHC was awarded its first Ryan White Title III award and recently, EHC received a continuation of its Ryan White Title III funding for an additional five years (2007-2011). EHC is the largest HIV provider in its service area, and has grown 29 percent in its patient volume during the past 12 months.

IV. Response to Findings

1. Issue #1 – Basis for Reimbursement of Partially Donated Physician Services

The Bureau of Financial Operations (BFO) determined that although Generally Accepted Accounting Principles (GAAP) allow for consideration of the valuation and allowability of physician "in-kind" donations to EHC, GAAP does not fully apply to the cost allowability question presented because HIM-15 is controlling for purposes of Medicare reimbursement.

DPW states in its Agreed Upon Procedures (AUP) for FQHCs that GAAP principles should apply to situations not covered by HIM-15 (Definitions, p. 16). In addition, HIM-15 states in its Forward: "For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied." EHC believes that HIM-15 does not consider its physician reimbursement structure and is therefore silent on the instant issue. HIM-15 drafters titled section 700 and the following subparts "Value of Services of Non-paid Workers." A reading of HIM-15 section 700 and the following subparts reveals that the drafters intended to create clear boundaries of what is an allowable cost to the state when attributing the services of non-paid workers as an expense in cost reporting. EHC believes that the principles outlined in HIM-15 by definition do not apply to the EHC physicians since they are paid.

Subpart 704.6, entitled "Value of Services to Non-Paid Workers", provides that reimbursable costs cannot include any imputed value for services of a worker who has received any direct remuneration. DPW cites this section in disallowing donated services. EHC believes this is an incorrect interpretation, and that this language was intended to reiterate that payment of salary or wages disqualifies a worker otherwise meeting the requirements of Section 700 and following subparts from being considered "non-paid". Thus, this section does not apply to a paid worker.

EHC believes that it and its patients received full value of the physicians' services and that physicians were, in effect, donating back to EHC the non-cash value of their services. This is the same view as that of the domestic accounting profession as evidenced by FASB #116, which requires that donated services be recorded as an expense with a corresponding donation.

EHC came to its conclusion that donated services should be included in the cost report by relying on the advice of one of the most respected and widely used Medicaid cost accountants in the state, Mr. William Tierney, CPA. The IAF, Detweiler, Hershey & Associates agreed with this conclusion and so stated in the AUP report. Exhibit E of the Audit Report incorrectly states that the IAF cites HIM-15 as the authority for including donated services. Page 4 of the AUP report states that FASB #116 is the basis for including donated services because HIM-15 does not apply.

DPW has stated that goods or services which are not paid for or accrued as an expense to the health center are not considered within the parameters of the DPW cost-based reimbursement. However, the AUP manual for FQHC's does permit in certain circumstances FQHC's to expense contingent reserves which are not actually a payment realized or an expense accrued. The AUP also allows for National Health Service Corps expenses not paid for by the FQHC to be considered part of the cost-based reimbursement from DPW. EHC believes that, while DPW does not generally reimburse goods or services which are not paid for by the FQHC, it does in some circumstances. EHC believes that charging DPW the in-kind portion of physician's salaries is analogous to the cited precedence allowed by DPW.

2. Issue # 1 - If HIM-15 Applies, its Application Supports Reimbursement of Partially Donated Physician Services

A. EHC believes that HIM-15, Section 700 and the following subsections articulates and narrowly defines methods for imputing value for cost-reporting purposes to non-paid workers. EHC believes that DPW wrongly applies these sections of HIM-15 to its paid physicians. However if DPW finds that its doctors' services fit within HIM-15, EHC then believes that it merits a fair and expansive reading of these sections.

While HIM-15 does not explicitly contemplate physician "in-kind" donations of professional services as allowable expenses when such physicians are receiving direct though below market salary remuneration from the FQHC, EHC argues it has in fact incurred the costs of and reimbursed these physicians in a manner analogous to what HIM-15 describes and allows in Section 704.6 as "perquisites" and "maintenance." Therefore, physician "in-kind" donations of services to EHC should be allowable.

HIM-15 clearly contains narrowly-tailored but permissive language which allows for certain workers affiliated with religious orders or churches to count volunteer work as allowable expenses to the entity providing health care services through such workers and to permit DPW to recognize such costs when such workers are under specific contractual arrangements or are receiving benefits in the form of perquisites and maintenance directly from the provider organization (HIM-15 704.6). EHC's practice from its inception has been to pay physicians and other providers a very modest salary that can properly be termed a maintenance payment akin to what a resident receives during their medical residency training period. During the audit periods, EHC paid its physicians substantially less than could be earned professionally elsewhere. That difference was, in effect, *donated* by the employed physicians so that EHC could provide more comprehensive health care to its patients. The physicians, during the audit period in question, had families to support, lived within a high cost of living area in southeastern Pennsylvania and had other material needs associated with supporting themselves and their families. The physicians absorbed those costs with modest salaries in order to allow a better service delivery system.

The size of the difference between salary paid and market value is so significant that it is unreasonable to exclude it from cost reimbursement. HIM-15 at Section 704.3 allows for consideration of the value of services to unpaid workers and at Section 704.6 further allows reimbursement for imputed value where compensation is in the form of "perquisites" and "maintenance". Undeniably, EHC provides a level of paid compensation but it is well-below market rates so that the explicit language of Section 704.5 is not fully applicable in that it refers to non-paid workers under specific contractual arrangements with separate organizations. Yet these partially-paid physicians are effectively performing a parallel function – EHC receives the full market value of their services as individuals rather than as members of a separate organization.

EHC physicians live in single family houses or apartments with families, and buy their own food and the other necessities of life. They, rather than a separate organization, are providing their own maintenance which is qualitatively and quantitatively different from that of an unmarried

people living in a communal setting. A third party could in principle provide these benefits but in these circumstances the individual chooses voluntarily to accept less salary and be "unpaid" for the remainder. EHC has a highly unusual model that was clearly not contemplated when HIM-15 was drafted and it should be interpreted to reflect the allowable value of the "unpaid" services donated. EHC asserts and is supported by its IAF that this practice is the same in principle to the allowable value of the unpaid religious workers which HIM-15 contemplates.

B. EHC further acknowledges that, consistent with the explicit terms of Section 704.5, though it did not have or contract with a separate organization to reimburse its physicians or donate their services in whole or in part, in intent and substance it meets the model contemplated for certain allowable costs as to such religious workers which provide voluntarily donated or "unpaid" services to the provider and EHC as the provider is entitled to claim the value of the those volunteer services

HIM-15 at Section 704.5 as to Catholic Church or religiously-affiliated workers was drafted with the intent to allow voluntary and unpaid services from certain workers to qualify as allowable expenses. Indeed one of the potential supporting documentation methods for claiming such reimbursement is evidence of voluntary donation of the services. At subsection D, the provider must demonstrate and substantiate that the services were donated. These physicians employed by EHC are paid below market and EHC can and has so documented that difference. The difference is then an allowable cost of "unpaid" or donated services within the intent of Section 704.5.

In the model described in that section where a religious organization is essentially the legal entity owning a provider clinic or health care facility and controls the separate organization which donates the services of the unpaid workers, the employment relationship is between two related parties. The Medicare Program and state Medicaid Programs usually consider related parties as "one organization" as to the allowability of costs and that principle should apply to EHC here. EHC asserts that if the related organizations contemplated by Section 704.5 are viewed as related parties and are allowed to claim the value of unpaid workers in whole or in part, that the same principle should apply to EHC in terms of claiming the partial unpaid value of its physicians' services. For example, a religious organization operates a clinic and controls a separate membership organization of physicians. The clinic has a legal obligation to pay the membership organization \$60,000 each year per physician. The membership organization agrees to forgive \$30,000 each year as a documented donation to the clinic and use the other \$30,000 actually paid to it to provide perquisites and maintenance for the physicians. From the perspective of the religious organization as a whole, it has spent \$30,000 but received \$60,000 in value of services through the physicians. Applying the same principle and logic to EHC, the single organization provides a payment of \$30,000 to each physician by way of below market salary and the physicians each donate the remaining \$30,000 to EHC. The two situations are then economically equivalent. Both the religious organization and EHC pay \$30,000 to the physicians and both should have the recognition of the total \$60,000 allowable cost under the intent of the HIM-15 principles.

EHC believes that the BFO has a moral and constitutional obligation to treat all faith-based organizations in an equitable manner and not provide special treatment to any particular type of

faith-based organization or model. EHC has an organizational structure different from the religious organizations that were the model for HIM-15, Chapter 7, so EHC should be fairly and similarly evaluated in light of its parallel but not identical structure. EHC believes that such an evaluation will support this just conclusion that the donated services it receives are no different in substance from those explicitly allowed by HIM-15, Chapter 7.

3. Issue #1 – EHC 's Use of Medical Assistance Funds Consistent with FOHC Purposes and Cost Reimbursement Principles

EHC has properly and effectively used for comprehensive clinical care the reimbursement received due to "in-kind" donations of salary by physicians and which costs were included in its allowable costs calculation

Inclusion of the value of "in-kind" contributions of the "unpaid" portions of physician market salaries in the DPW cost reimbursement calculations and cost reports for the audited years clearly resulted in larger payments to EHC for those base years of 1999 and 2000, as well as in subsequent years. EHC used these monies to provide enhanced patient care consistent with all allowable and applicable cost reimbursement principles. There has been no misuse of funds for otherwise unallowable purposes.

Since 1999, EHC has not significantly increased its balance sheet net assets, as demonstrated by the slight increase in net assets from \$450,800 at March 31, 2002 to \$461,600 as of the June 30, 2006 balance sheet. All actual revenues were used for patient care or related allowable purposes.

In October 1999, EHC moved to a new location which provided much-needed additional space and an improved clinical layout. The rent at the new location increased from \$44,000 to \$179,000 per year, and subsequent increases have brought it to \$202,000 per year. The 1999-2000 base year cost factor reflects a blended rent cost of about \$70,000 per year, so the additional cost of \$109,000 to \$132,000 per year has been effectively covered by the cost reimbursement related to the imputed value of the "in-kind" component of physician salaries in aggregate.

EHC's target population is largely Spanish speaking, poorly educated, with high rates of chronic illness inextricably woven together with often devastating social and mental health issues. To make a significant impact on these complex health and social issues requires an increased intensity of primary medical services. It is the substantial task of the primary care provider to sort out these needs, making appropriate referrals to mental health, social work, and medical specialists, as well as providing necessary acute, chronic, and preventive interventions. EHC routinely does not see as many patients per physician as compared to other FQHC's. Because of this reduced inpatient volume EHC has a reduced cost reimbursement factor. EHC believes that the allowance of the "in-kind" services component of its reimbursement was used to cover the cost of slightly longer and more comprehensive and effective appointments.

4. Issue #1 – Amount of In-Kind Services Provided

EHC believes that the amounts shown as disallowed for in-kind provider compensation may be overstated as they exceed the in-kind included in the AUP report. The disallowed amounts exceed the in-kind by \$1,228 and \$11,630 for 1999 and 2000, respectively.

5. Issue #2 - Insurance Costs

BFO contends that the cost report overstates certain insurance costs. EHC does not dispute this finding. In the future EHC will maintain a schedule of insurance data as recommended by the audit report.

6. Issue #3 - Collection Fees Were Miscalculated in 2000

BFO maintains that a collection fee was miscalculated. EHC does not dispute this finding. EHC agrees this is a one time error which should not reoccur. No specific action is planned.

7. Miscellaneous Comment on Audit Report

Exhibit E of the BFO Audit Report notes that EHC is located in a lower middle class neighborhood. This description is accurate in that EHC's main office is located in such an area, while approximately 80% of EHC's patients live below the poverty level. The target patient resident area specified in EHC's Section 330 grant includes 8 of the 10 lowest income census tracts in Philadelphia. In August 2006, EHC opened a satellite office in the lowest income census tract in Philadelphia.

8. EHC Conclusion

EHC believes that allowing physician "in-kind" donations as a reimbursable cost is fully justified. EHC believes that HIM-15, Chapter 7 is inapplicable to paid workers, that GAAP accounting rules apply and donated services are properly reported as an expense and a donation. Even if the BFO disagrees with this reasoning, a fair and expansive interpretation would conclude that the substance of EHC's donated services meet the intent of HIM-15. HIM-15 clearly contemplated some unpaid and well-documented volunteer activities to be allowed as reimbursable costs to FQHCs and other health care providers. EHC believes that had the original drafters of HIM-15 contemplated EHC's "maintenance type" payments to physicians that they would have drafted express language in HIM-15 to support this position. EHC believes that the language in HIM-15 to limit "in-kind" donations was meant to protect DPW from Medicaid Program providers who attempt to misrepresent or to manipulate allowable costs by inflating the value of donated services. EHC would have incurred the costs of services but for the donated services and it should be able to claim that cost value. EHC provided through its physicians the **full** value of their services and even gave more value to its patients. EHC's intent and motives have not been in any way to manipulate; in fact, physician salaries have been so far below the RCLs that EHC believes it would be a significant financial and service delivery injustice to

exclude the "in-kind" donations from reimbursable costs since total salary inclusive of donated services represents the true cost of such services.

V. Response to Result 4 – Hardship Imposed by Recommended Retrospective Change in Reimbursement Rates

The recommendation of the BFO auditors to reduce reimbursement rates to \$88.43 in 1999 and \$104.55 in 2000, now seven years after the costs were incurred and the revenues expended, will produce overwhelming patient and professional hardship. EHC believes that the rates that were provisionally provided should be maintained, according to GAAP principles as outlined previously.

The effect of changing these rates is to eliminate the donations that the physicians have been making to the North Philadelphia community. The personal sacrifices made by these dedicated medical professionals were intended to produce an increased financial capacity for EHC to provide the most holistic, comprehensive care possible for this community. By reducing these rates, DPW is in effect eliminating the donated cost and contributions made by these physicians. Rather than giving their time to the community, they have in effect given it to the Commonwealth of Pennsylvania. It is incomprehensible that these physicians will continue to accept employment at these salaries if there is no added benefit to the community. EHC will not be able to recruit and retain physicians in the cost structure that is being recommended.

During the years that EHC has been operating within the provisional rate structure, thousands of patients have been served. Along the way, revenue from these services provided has been poured back into the health center in the form of additional patient care. EHC has increased its scope of services throughout the year to increase services to patients.

The ramifications of disallowing the "in-kind" services provided by the physicians and mid-level providers would not only pose a barrier for the continuation of EHC, but it would result in significant hardships for the Spanish-speaking communities in North Philadelphia who need access to health care services. Frankly speaking, should these "in-kind" costs be disallowed for 1999 and 2000 and in the years following, EHC will be forced to declare bankruptcy and discontinue operations.

VI. EHC's Request for OMAP's Forbearance

While EHC in no way concedes to the findings of the DPW auditors, we nevertheless recognize the need to quickly come to agreement with the OMAP regarding the continued service of EHC in our community. We request that OMAP consider our request for resolving this dilemma as follows:

1. EHC will agree to move forward with future cost reports that do not include in-kind contributions as an expense and, with recognition by DPW that the regulations for this particular situation have been unclear, we would like to request that no repayment from EHC

be requested for the past. We would also like to make this request for special consideration because repayment would place an extreme financial burden on the health center that would result in a hardship to the community we serve. Should we cease to operate, thousands of current patients, especially those whose first language is Spanish, would face a crisis of lack of access to appropriate comprehensive care services. We make this request because it would be impossible for us to repay this amount and continue in operations as a health center serving our community. The cost of these donations has already been borne by the physicians in reduced compensation.

2. In light of the time delay in determining and communicating the results of the audit that would normally have been completed years ago, we would like to request that the reductions in reimbursement rates following 2000 not be considered until there is an opportunity for EHC to develop a cost structure that can be appropriately set for past years following 2000. The length of time that EHC has been operating with provisional rates that went undisputed is significant. EHC during those years has continued to grow in scope and has planned its services on a cost structure that was unchallenged until recently. The cumulative effect of a substantial decrease in its cost structure over seven years creates a debt that EHC would be unable to repay and sustain itself for the future. This would either terminate EHC's ability to operate or substantially cripple it financially for the foreseeable future.
3. EHC would like to request that OMAP, by way of special consideration, allow EHC a period of one year to restructure its operations and construct an equitable resolution regarding its rate structure by allowing EHC to operate with its current reimbursement rate for the next fiscal year (July 1, 2007 – June 30, 2008). This time will allow EHC stability moving forward as it makes all necessary changes to comply with all OMAP regulations. This forbearance will also allow EHC to restructure the physician's salaries to an equitable level since donated time will not be reimbursed. Fairness for these committed medical providers demands that, should donated services not be allowed for the benefit of patient care, that the opportunity is provided to them to receive market compensation.
4. EHC requests that OMAP allow EHC to re-establish a new base year for its cost structure, based on a new base year mutually agreed upon (at the earliest fiscal year possible - July 1 2007 through June 30, 2008). This delay will allow EHC to restructure its costs and compensation to fit the DPW view of HIM-15 and take into consideration the changes in scope that EHC has undertaken during the past seven years for which it has not requested additional rate increases. This request is made based on the following regulation from the FQHC manual:

DPW will adjust an FQHC's or RHC's rate to account for any increase or decrease in the scope of services any time that the FQHC/RHC has received approval for a change in the scope of services from the United States Department of Health and Human Services, Public Health Service. Additionally, DPW will consider extraordinary circumstances or unusual one-time occurrences that might have substantial cost effects in the current or future years. For subsequent FYs following any adjustment for change in scope of services, payment will be set by using the MEI method used for other centers/clinics.

EHC requests this consideration because of the changes in scope it made during the years 2001 through 2007, the most significant one being the changes in scope made in 2006 which were associated with its becoming a full FQHC (additional site, increased medical providers and services, etc). Secondly, this request is being made as this seems to be an extraordinary and unusual circumstance as contemplated by the language quoted above.