



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
**BUREAU OF FINANCIAL OPERATIONS**  
3<sup>rd</sup> Floor, Bertolino Building  
Harrisburg, Pennsylvania 17105-2675

AUG 11 2008

TELEPHONE NUMBER  
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KEVIN M. FRIEL  
DIRECTOR

Mr. Marco Giordano  
Chief Accounting Officer  
Resources for Human Development  
4700 Wissahickon Avenue  
Suite 126  
Philadelphia, Pennsylvania 19144

Dear Mr. Giordano:

I am enclosing the final report of Resources for Human Development recently completed by this office. Your response has been incorporated into the final report and labeled as Appendix.

I would like to express my appreciation to all the courtesy extended to my staff during the course of fieldwork. I understand that you were especially helpful to Timothy Rausch in expediting the audit process.

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 the OMAP may be in contact with you to follow-up on the action taken to comply with the report's recommendations.

If you have any questions concerning this matter, please contact Alex Matolyak, Audit Resolution Section at (717) 783-7786

Sincerely,

A handwritten signature in cursive script that reads "Kevin M. Friel".

Kevin M. Friel

cc: Ms. Donna L. Torrasi  
Mr. Michael Johnston  
Mr. Michael Nardone  
Ms. Brenda Tewell



COMMONWEALTH OF PENNSYLVANIA  
DEPARTMENT OF PUBLIC WELFARE  
BUREAU OF FINANCIAL OPERATIONS  
ROOM 525 HEALTH & WELFARE BUILDING  
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AUG 11 2008

KEVIN M. FRIEL  
DIRECTOR

TELEPHONE  
(717) 772-2231  
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(717) 787-3560

Mr. Michael Nardone  
Deputy Secretary for Medical Assistance Programs  
Health and Welfare Building, Room 515  
Harrisburg, Pennsylvania 17120

Dear Mr. Nardone:

In response to a request from the Office of Medical Assistance Programs (OMAP), the Bureau of Financial Operations (BFO) has completed an audit of the Independent Auditing Firm's application of Agreed Upon Procedures (AUP) to Resources for Human Development, Inc. (RHD), a Federally Qualified Health Center (FQHC) who filed Cost Reports for the fiscal years ended June 30, 1999 and 2000. The audit was made in response to a request to assess the periodic rate for encounters. As such, the audit's goal was to determine an encounter rate which includes only allowable program costs.

The audit questions the eligibility of costs as stated on Exhibits A and B:

- Total related costs in the amount of \$42,044 and \$49,991 for the fiscal years ended June 30, 1999 and 2000, respectively.

The application of these adjustments to allowable costs resulted in a medical per diem of \$210.33 for the fiscal year ended June 30, 1999 (Exhibits C and E) and a medical per diem of \$263.19 for the fiscal year ended June 30, 2000 (Exhibits D and F).

**Resources for Human Development, Inc. FQHC**  
**Executive Summary**

RHD is a not for profit corporation with business offices and a Health Center at 4700 Wissahickon Avenue, Philadelphia, PA 19144. During the audit period, it also had another Health Center at the Abbottsford Housing Project on Ridge Avenue, Philadelphia, PA 19127.

One of RHD's operating units is a FQHC. FQHCs are "safety net" providers whose main purpose is to enhance primary care services in underserved urban and rural communities. FQHCs are considered suppliers of Medicare services and are paid an all-inclusive per visit rate (Encounter Rate) based on reasonable cost incurred and reported on an annual Cost Report. The Encounter Rate is computed by dividing the

**Resources for Human Development, Inc.**  
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FQHCs total allowable cost by the number of visits for all FQHC patients. Once established, the Encounter Rate increases by the Medicare Economic Index applicable to primary care physician services.

The report findings and recommendations for corrective action are summarized below:

FINDINGS	SUMMARY
<p><b><i>Finding No. 1 - Group Education Costs Were Reclassified From Direct Costs To Non FQHC Costs.</i></b></p>	<p>The AUP Report disallowed Group Education Costs from Line 3 of Direct Expenses. However, this expenditure would have more accurately been classified as a Non FQHC Cost. Therefore, on this Report, Line 41 of the Cost Reports entitled "Education/Outreach" was increased for a total of \$2,089 and \$1,929 for the fiscal years ended June 30, 1999 and 2000, respectively.</p>

HIGHLIGHTS OF RECOMMENDATIONS
<p>OMAP should:</p> <ul style="list-style-type: none"> <li>• Add a total of \$2,089 and \$1,929 to Line 41, Education/Outreach for the fiscal years ended June 30, 1999 and 2000, respectively.</li> </ul> <p>RHD should:</p> <ul style="list-style-type: none"> <li>• List expenditures not directly related to FQHC activities as Non FQHC Costs.</li> </ul>

FINDINGS	SUMMARY
<p><b><i>Finding No. 2 Medical Supplies Were Overstated For The Cost Of Food And Beverage Provided At Meetings And For A Teen Outreach Program.</i></b></p>	<p>Direct costs for Line 19, Medical Supplies were overstated due to inclusion of cost for food and beverages supplied for meetings and for the cost of teen outreach program. A total of \$1,903 and \$1,677 were disallowed for the fiscal years ended June 30, 1999 and 2000, respectively. Line 20 also included community outreach costs of \$290 and \$649 that were disallowed for the years ended June 30, 1999 and 2000.</p>

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 FQHC Cost Reports  
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HIGHLIGHTS OF RECOMMENDATIONS
<p>OMAP should</p> <ul style="list-style-type: none"> <li>• Make the necessary adjustments to decrease Line 19 by \$1,903 and \$1,677 for the years ended June 30, 1999 and 2000, respectively.</li> <li>• Make the necessary adjustments to decrease Line 20 by \$290 and \$649 for the fiscal years ended June 30, 1999 and 2000, respectively.</li> </ul>

FINDINGS	SUMMARY
<p><b><i>Finding No. 3- RHD Incorrectly Included Imputed Rents And Utility Costs On Its Cost Reports</i></b></p>	<p>Certain rents and utility costs were not paid but were nonetheless included on the Cost Reports as a result of the free use of space donated by a quazi-governmental agency. However the imputed value of a donation is non reimbursable. A total of \$36,691 and \$33,364 was disallowed for the fiscal years ended June 30, 1999 and 2000, respectively.</p>

HIGHLIGHTS OF RECOMMENDATIONS
<p>OMAP should:</p> <ul style="list-style-type: none"> <li>• Disallow a total of \$2,664 and \$7,780 of Line 62, Utilities for the fiscal years ended June 30, 1999 and 2000, respectively.</li> <li>• Disallow a total of \$34,027 and \$25,584 from Line 63, Rents for the fiscal years ended June 30, 1999 and 2000, respectively.</li> </ul>

FINDINGS	SUMMARY
<p><b><i>Finding No. 4-The Allocation Of Administrative Overhead Costs Was Overstated.</i></b></p>	<p>Lines 71 of the Cost Reports entitled RHD Administrative Overhead were overstated due to the method of allocation of overhead expenses. A total of \$4,676 and \$16,093 was disallowed for the fiscal years ended June 30, 1999 and 2000, respectively.</p>

**Resources for Human Development, Inc.  
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HIGHLIGHTS OF RECOMMENDATIONS
<p>OMAP should:</p> <ul style="list-style-type: none"> <li>Disallow a total of \$4,676 and \$16,093 of Line 71, for the fiscal years ended June 30, 1999 and 2000, respectively.</li> </ul> <p>RHD should:</p> <ul style="list-style-type: none"> <li>Adhere to the revised method of allocation of overhead costs.</li> </ul>

FINDINGS	SUMMARY
<p><b><i>Finding No. 5-Fines And Other Unidentified Expenditures Were Disallowed.</i></b></p>	<p>Line 69 entitled Other Miscellaneous Expenses was overstated due to inclusion of unidentified expenditures of \$573 for the fiscal year ended June 30, 1999. Line 9 entitled Patient Transportation was overstated due to the inclusion of fines of \$137 for the fiscal year ended June 30, 2000.</p>

HIGHLIGHTS OF RECOMMENDATIONS
<p>OMAP should:</p> <ul style="list-style-type: none"> <li>Disallow \$573 from Line 69 for the fiscal year ended June 30, 1999.</li> <li>Disallow \$137 from Line 9 for the fiscal year ended June 30, 2000.</li> </ul> <p>RHD should:</p> <ul style="list-style-type: none"> <li>Not request reimbursement for fines.</li> <li>Be able to identify and to substantiate all costs.</li> </ul>

**Background**

RHD operates Health Care Centers located in the City of Philadelphia that provide a broad range of health services to a largely medically underserved population.

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 Reimbursements 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.

RHD submitted Cost Reports for the fiscal years ended June 30, 1999 and 2000 that were subject to audit by an Independent Certified Public Accounting Firm (IAF). The IAF based its review on the Providers adjusted general ledger and made entries to

**Resources for Human Development, Inc.**  
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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 of its work and reviewed its work papers. Based on the recommendations of the OMAP, 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 as otherwise noted.

**Objective, Scope and Methodology**

The audit objective, developed in concurrence with OMAP was:

- To determine the actual allowable cost of services to FQHC customers and to determine that the underlying expenditures are reasonable, consistent with Medical Assistance cost principals and attributable to RHD.

In pursuing this objective, the BFO interviewed management and staff members from RHD. We also reviewed accounting records, financial records, timesheets, records of encounters and other pertinent data necessary to complete our objective.

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 the effectiveness of these controls. Based on our understanding of the controls, no material deficiencies came to our attention. Areas where we noted an opportunity for improvement in management controls are addressed in the findings of this report.

Fieldwork for this audit took place between April 8, 2008 and April 30, 2008 based on available records and was performed in accordance with General Instructions for Completion of the Medical Assistance Cost Report. The Report, when presented in its final form, is available for public inspection.

**Results of Fieldwork**

**Finding No. 1 – Group Education Costs Were Reclassified From Direct Costs To Non FQHC Costs.**

The AUP Report disallowed Group Education Expenses from Line 3. Rather than disallowing the expenditures, the IAF should have reclassified the Group Education Expenses to Non FQHC Costs. In order to correct this, the Direct Costs were first increased so as to reverse the IAF's adjustment then the amounts were reclassified by decreasing Direct Costs and increasing non FQHC Costs.

As such, this Report increases Non FQHC costs by \$2,089 and \$1,929 for the fiscal years ended June 30, 1999 and 2000, respectively.

**Resources for Human Development, Inc.**  
**FQHC Cost Reports**  
**July 1, 1998 through June 30, 2000**

**Recommendations**

The BFO recommends that the expenditures associated with Non FQHC activities be increased in the amount of \$2,089 and \$1,929 for the fiscal years ended June 30, 1999 and 2000, respectively.

**Finding No. 2 – Medical Supplies Were Overstated For The Cost of Food And Beverages Provided At Meetings And For A Teen Outreach Program.**

The cost of food and beverages provided during administrative meetings is unallowable under the HIM-15 guidelines, Section 2145. The food and beverages were not solely for RHD's benefit and related to patient care but rather they were for the convenience of the administrative staff, whose meals and beverages could be taken at any time or in any place. An example of an allowable food or beverage cost would be when provided to nurses or doctors who must remain on call on premises to provide patient care.

A reclassification of the applicable costs is appropriate because it was determined that this was a Non FQHC activity. Total direct costs of \$1,903 and \$1,677 should be disallowed from Line 19 for the fiscal years ended June 30, 1999 and 2000, respectively.

Expenditures of \$290 and \$649 were disallowed for the fiscal year ended June 30, 1999 and 2000 in regard to a Teen Outreach Program that was outside of the scope of FQHC activities.

**Recommendation**

The BFO recommends \$1,903 and \$1,677 be disallowed from Line 19, Medical Supplies for the fiscal years ended June 30, 1999 and 2000, respectively.

The BFO also recommends that \$290 and \$649 be disallowed from Line 20, Staff Expenses for the fiscal years ended June 30, 1999 and 2000, respectively.

**Finding No. 3 – RHD Incorrectly Included Imputed Rents And Utility Costs On Its Cost Reports.**

RHD was allowed temporary quarters in trailers owned by the City of Philadelphia's Department of Housing (City) for one of its clinics. The City absorbed the cost of utilities and charged no cash rents to RHD. RHD's books and records made no provision for these transactions. In preparing its Cost Reports, RHD imputed a rental value for the use of the trailers and for utility services provided.

The regulations provide that the value of the donated use of land or buildings is not a reimbursable cost (HIM 15 – Section 610) and, as such, these imputed values should be disallowed.

**Resources for Human Development, Inc.**  
**FQHC Cost Reports**  
**July 1, 1998 through June 30, 2000**

**Recommendation**

The BFO recommends that \$2,664 and \$7,780 be disallowed from Line 62, Utilities of the cost Reports for the fiscal years ended June 30, 1999 and 2000, respectively. In addition, the BFO recommends that \$34,027 and \$25,584 be disallowed from Line 63, Rents for the fiscal years ended June 30, 1999 and 2000, respectively.

**Finding No. 4 – The Allocation Of Administrative Overhead Costs Was Overstated.**

Line 71, RHD Administrative Overhead was overstated for both years due to the method of allocation utilized. The BFO's review indicated that \$4,676 and \$16,093 should be disallowed for the fiscal years ended June 30, 1999 and 2000, respectively.

**Recommendation**

The BFO recommends that \$4,676 and \$16,093 be disallowed from Line 71 for the years ended June 30, 1999 and 2000, respectively.

**Finding No. 5 – Fines And Other Unidentified Expenditures Were Disallowed.**

Line 69, Other Miscellaneous Expenses was overstated due to the inclusion of unidentified expenditures of \$573 for the fiscal year ended June 30, 1999. Line 9, Patient Transportation was overstated due to the inclusion of fines of \$137 for the fiscal year ended June 30, 2000.

**Recommendation**

The BFO recommends that \$573 be disallowed from Line 69 for the fiscal years ended June 30, 1999 and that \$137 be disallowed from Line 9 for the fiscal year ended June 30, 2000.

RHD did not request an exit conference. RHD did submit a response, and the response has been included in this report, and labeled as an Appendix

In accordance with the BFO established procedures, please provide a response within 60 days to the Audit Resolution Section concerning actions to be taken to ensure the report recommendations are implemented.

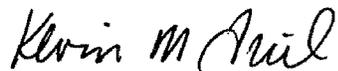
**Resources for Human Development, Inc.**

**FQHC Cost Reports**

**July 1, 1998 through June 30, 2000**

Please contact Alex Matolyak, Audit Resolution Section at (717) 783-7786 if you have any questions concerning this audit or if we can be of any further assistance in this matter.

Sincerely,



Kevin M. Friel

Attachments

cc: Mr. Marco Giordano  
Ms Donna L Torrasi  
Mr. Michael Johnston  
Mr. William Miller  
Ms. Brenda Tewell

## **EXHIBITS**

**RESOURCES FOR HUMAN DEVELOPMENT, INC.  
BFO ADJUSTMENTS  
FOR THE YEAR ENDED JUNE 30, 1999**

	Per Cost Report	BFO Adjustments	Final Allowable
Total Direct FQHC Costs	\$ 576,204	\$ (2,193)	\$ 574,011
Non FQHC Costs	<u>\$ 64,512</u>	<u>\$ 2,089</u>	<u>\$ 66,601</u>
Total Direct Costs	\$ 640,716	\$ (104)	\$ 640,612
Overhead Costs	<u>\$ 647,770</u>	<u>\$ (41,940)</u>	<u>\$ 605,830</u>
Total Costs	<u>\$ 1,288,486</u>	<u>\$ (42,044)</u>	<u>\$ 1,246,442</u>

**BFO Adjustments**

**Direct Costs**

Line 19-Medical Supplies	\$ (1,903)
Line 20-Phelbotomists	<u>(290)</u>
Decrease in Direct Costs	<u>\$ (2,193)</u>

**Non FQHC Costs**

Line 41-Education/Outreach	<u>\$ 2,089</u>
Increase in Non FQHC Costs	<u>\$ 2,089</u>

**Overhead Costs**

Line 62-Utilities	\$ (2,664)
Line 63-Rent	(34,027)
Line 69-Other Miscellaneous	(573)
Line 71-RHD Overhead	<u>(4,676)</u>
Decrease in Overhead Costs	<u>\$ (41,940)</u>
NET DECREASE IN COSTS	<u>\$ (42,044)</u>

**EXHIBIT A**

**RESOURCES FOR HUMAN DEVELOPMENT, INC.  
BFO ADJUSTMENTS  
FOR THE YEAR ENDED JUNE 30, 2000**

	Per Cost Report	BFO Adjustments	Final Allowable
Total Direct FQHC Costs	\$ 592,819	\$ (2,463)	\$ 590,356
Non FQHC Costs	<u>67,679</u>	<u>1,929</u>	<u>69,608</u>
Total Direct Costs	660,498	(534)	659,964
Overhead Costs	<u>852,645</u>	<u>(49,457)</u>	<u>803,188</u>
Total Costs	<u>\$ 1,513,143</u>	<u>\$ (49,991)</u>	<u>\$ 1,463,152</u>

**BFO Adjustments**

**Direct Costs**

Line 9-Patient transportation	\$ (137)
Line 19-Medical Supplies	(1,677)
Line 20-Staff Expenses	<u>(649)</u>
Decrease in Direct Costs	<u>\$ (2,463)</u>

**Non FQHC Costs**

Line 41-Education/Outreach	<u>\$ 1,929</u>
Increase in Non FQHC Costs	<u>\$ 1,929</u>

**Overhead Costs**

Line 62-Utilities	\$ (7,780)
Line 63-Rents	(25,584)
Line 69-RHD Administrative Overhead	<u>(16,093)</u>
Decrease in Overhead Costs	<u>(49,457)</u>

NET DECREASE IN COSTS	<u>\$ (49,991)</u>
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**EXHIBIT B**

**RESOURCES FOR HUMAN DEVELOPMENT, INC.  
DETERMINATION OF OVERHEAD APPLICABLE TO FQHC SERVICES  
FOR THE YEAR ENDED JUNE 30, 1999**

1 Total Direct FQHC Health Care Costs	\$ 574,011
2 Total Direct Costs	640,612
3 Percentage of Direct Cost Applicable to FQHC Health Services (Line 1 Divided by Line 2)	89.6035%
4 Total Overhead Costs (Page 3, Column 13, Line 79)	605,830
5 Overhead Costs Applicable to FQHC Health Services Line 4 Multiplied by Line 3	\$ 542,845

**EXHIBIT C**

**RESOURCES FOR HUMAN DEVELOPMENT, INC.**  
**DETERMINATION OF OVERHEAD APPLICABLE TO FQHC SERVICES**  
**FOR THE YEAR ENDED JUNE 30, 2000**

1 Total Direct FQHC Health Care Costs	\$ 590,356
2 Total Direct Costs	659,964
3 Percentage of Direct Cost Applicable to FQHC Health Services (Line 1 Divided by Line 2)	89.4528%
4 Total Overhead Costs (Page 3, Column 13, Line 79)	803,188
5 Overhead Costs Applicable to FQHC Health Services (Line 4 Multiplied by Line 3)	\$ 718,474

**EXHIBIT D**

**RESOURCES FOR HUMAN DEVELOPMENT, INC.  
SCHEDULE OF REIMBURSABLE RATES  
FOR THE FISCAL YEAR ENDED JUNE 30, 1999**

	<b>MEDICAL</b>
1 Total Direct FQHC Health Care Costs	\$ 574,011
2 Percent of Distribution *	100%
3 Overhead Costs Applicable To FQHC Services	\$ 542,845
4 Total Costs Applicable To FQHC Services ( Line 1 + Line 3)	\$ 1,116,856
5 Total Provider Encounter	5,310
6 Reimbursable Rates ( Line 4/ Line 5)	\$ 210.33

\* Actual decimal carried to six places.

**RESOURCES FOR HUMAN DEVELOPMENT, INC.  
SCHEDULE OF REIMBURSEABLE RATES  
FOR THE FISCAL YEAR ENDED JUNE 30, 2000**

	<b>MEDICAL</b>
1 Total Direct FQHC Health Care Costs	\$ 590,356
2 Percent of Distribution *	100.00%
3 Overhead Costs Applicable To FQHC Services	\$ 718,474
4 Total Cost Applicable To FQHC Services( Line 1 + Line 3)	\$ 1,308,830
5 Total Provider Encounters	4,973
6 Reimbursable Rates ( Line 4/ Line 5)	\$ 263.19

\* Actual decimal carried to seven places.

## APPENDIX



RESOURCES  
FOR  
HUMAN DEVELOPMENT, INC.

July 11, 2008

**Via Federal Express First Overnight**

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

**Re: Responses to DPW Audit: July 1, 1999 through June 30, 2000 Cost Reports**

Dear Mr. Higgins;

The enclosed document contains responses to the findings noted from the audit of our costs reports covering July 1, 1998 through June 30, 2000. We also included exhibits for further clarification.

Please contact us if you have any questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Donna L. Torrissi'.

Donna L. Torrissi, MSN  
Network Executive Director

A handwritten signature in cursive script, appearing to read 'Michael Johnston'.

Michael Johnston, CPA  
FPCN Fiscal Director

Cc: Marco Giordano  
Michael Johnston  
Peg Morrison

Attachment  
1 of 86

**Finding No. 1 – Group Education costs were reclassified from direct costs to non FQHC costs.**

RHD's Response:

We agree with the group education /outreach adjustments.

**Finding No. 2 – Medical supplies were overstated for the cost of food and beverages provided at meetings and for a teen outreach program.**

RHD's Response:

We disagree with the food and beverage adjustments provided for the internal staff meetings. The Medicare HIM 15-1 Section 2144 & 2145 allows cafeteria cost incurred in the provider setting. These costs are for staff or manager meetings during non-patient care hours for administrative, quality care, and training purposes. We have enclosed an allowable cafeteria meal cost argument (Exhibits 3) and IRS Fringe Benefit Publication 15-B meals cost sections (Exhibit 1) and the HIM 15-1 sections 2144 & 2145 Employee Personnel Meal Cost (Exhibit 2).

Please provide us with the Medicare and Medicaid regulations disallowing this type of cafeteria meal cost. Hospitals and Nursing Homes do not have their net cafeteria cost removed from their PA Medicaid cost reports. These meals are not from a public vending machine or a snack shop operation. RHD is providing these benefits for the convenience of the staff and for convenient patient access to providers (physician & mid-levels). As a Part A Medicare facility provider, FQHCs do not encourage providers leaving the health center premises during business hours and non-business hours (especially lunchtime). The minimum requirements of construction and equipment for hospitals and medical facilities, DHHS Publication (HRA) 14500 regulations published under the Title VI of the Public Health Service Act requires employee cafeteria space (lounge) as well as a meeting/conference space (Exhibit 4 & 5). The 1996-1997 Hospital and Health Care Facilities Construction Guidelines (Exhibits 5 – 3 pages) displays an outpatient requirement for multi-purposes room(s) equipped for visual aids shall be provided for conferencing, meetings, and health education purposes. Also, staff toilet and lounge areas must be separated from the public and patient facilities. Most outpatient facilities have multipurpose room(s) that can serve as meeting rooms, lounges, a dining area and patient health education classrooms. Eating meals and drinking in these multi-purpose rooms coincides with work related activity and should be allowable.

**Finding No. 3 RHD incorrectly included rents and utility costs on its cost reports.**

RHD's Response: *History-Authorizing Legislation –Source: PHPC 101 All-Grantees Meeting-Washington, DC, June 25, 2008*

In 1990, the Public Health Service Act was amended to include Disadvantaged Minority Health Improvement Act, which under Section 340A, established the Health Services for Public Housing Residents program, known as the Public Housing Primary Care (PHPC) Program. The cornerstone of the PHPC program is the 340A legislative requirement that grantee programs are to be located on the premises of public housing or at locations immediately accessible to residents of public housing. In 1996, the Health Centers' Consolidation Act replaced Section 340A of the Public Health Service Act and consolidated the Health Care for the Homeless, Migrant Health Centers and the Public Housing Primary Care Programs under Section 330 of the Consolidation Act, Public Law 104-299. The Health Centers' Consolidation Act was reauthorized in 2006.

In 1991, the Department of Health and Human Services (DHHS), Health Services and Resources Administration (HRSA), established the Public Housing Primary Care (PHPC) Program and funded the first seven health center grantees. Family Practice and Counseling Network, Resources for Human Development, Philadelphia, Pennsylvania was one of the first seven PHPC health centers.

### **Housing Authorities and Resident Councils Partnerships**

PHPC program have established highly effective partnerships with the public housing authorities and resident/tenant organizations to facilitate the delivery of services. These partnerships also included collaboration with state and local managed care system. Residents are actively involved in the design of services and program governance, and are routinely trained or employed as outreach workers and case managers. HUD and HRSA are currently working closely to establish a Memorandum of Understanding (MOU) for collaborating future activities.

### **Becoming a PHPC program**

In general, PHPC grantees must demonstrate compliance with all section 330(e) and section 330(i) requirements, as well as all applicable HRSA guidelines.

Specific Section 330(i) includes:

- A) Formal Agreement with the local Public Housing Authority
- B) Resident involvement in the planning, implementation and management of the program.

The Questioned Health Center rent expense and utility cost was included into the cost report for the following reasons:

- 1) Philadelphia Housing Authority is a related party governmental agency (Exhibit 14) and a partner with RHD since 1991(Exhibits 11, 12, 15, 16, 23 ).
- 2) PHA had a license agreement with RHD (Exhibit 23) prepared by Mrs. Tine Hansen-Turton, a former PHA executive in 1997 which was signed by both parties. The contract allowed RHD to treat patients at Schuylkill Falls Health Center (SFHC) at PHA's expense. A \$1.00 rent and utilities cost was required RHD payments. The SFHC was managed by the SF Tenant Council Association (SFTC) but it was not a party in the PHA license agreement.

- 3) The four (4) apartment units were taken out of the Abbottsford Housing project inventory in 1991 and used as a Health Center until November 2007.
- 4) A Memo of Understanding for Abbottsford Health Center was executed on June 3, 1993 between RHD and AHTMC Abbottsford Homes Tenant Management Corporation for management and building maintenance (Exhibit 8). A majority voting control was assigned to the AHTMC.
- 5) A Memo of Understanding for both Abbottsford & Schuylkill Falls Health Center was executed on October 3, 1995 between RHD and AHTMC (Abbottsford Homes Tenant Management Corporation) and SFTC (Schuylkill Falls Tenant Council) for the management and building maintenance. A majority voting control was assigned to the AHTMC and SFTC.
- 6) The Tenant Councils expenditures were funded directly by HUD under a specific federal regulation and not by PHA.
- 7) On July 10, 2008, Mrs. Tine Hanson-Turton, JD a former PHA executive (Exhibit 25-resume) and presently a PHMC executive confirmed the fact that a PHA License Agreement and two (2) Memo of Understandings were executed. Her phone number is 215-731-7140 and email address is [tine@phmc.org](mailto:tine@phmc.org).
- 8) PHA is a governmental agency, both public and political and a part of the PA executive government branch. This fact was confirmed with a PHA Compliance Officer, Mr. Virginus Bragg, PHA Compliance Officer (215-684-4295) on July 9, 2008 (Exhibits 14 & 23).
- 9) PHA or its related Tenant Councils paid for the SFHC's utilities (gas, electric, & water) otherwise the services would have been shut off.
- 10) PHA through its HUD (Housing & Urban Development) funding paid for the 4 Abbottsford apartment building shell cost and the Schuylkill building health care center since HUD funded the construction and financing of the Housing Projects. This fact was confirmed by Mrs. Tine Hansen-Turton, former PHA Executive.
- 11) The \$533 rent expense that RHD two (2) health centers are requesting is only for the monthly amount a tenant/owner would be paying.
- 12) The actual apartment facility shell cost is substantially more than a tenant payment. Actual cost is the result of taking the construction and the financing cost, spreading it over the life of the building or the loan, in the form of depreciation, amortization and interest expense.
- 13) PHA construction and housing operations is funded almost entirely through a US Housing and Urban Development (HUD) grant annually.
- 14) HUD and HRSA have been trying to work out an interagency agreement for over 10 years. We were unable to receive a draft copy. Please refer to HUD Health Network & Goals Exhibits 12, 13, 14 & 17 and to HRA mission (Exhibit 7) for some public housing healthcare goals.

### **First Argument for Rent and Utility Allowable Cost**

**PHA is a Governmental Related Organization under HIM 15-1 Section 1000-1011.7 (Exhibit 6)**

The Medicare and Medicaid regulations do allow essential and necessary cost to be paid by related organizations. RHD believes that the Philadelphia Housing Authority (PHA) is a related organization because HRSA requires partnering with housing authorities as a Section 330 (i) grant requirement (Exhibit 7). The RHD health center was located within the housing facility. RHD refitted 4 apartments into the Abbottsford Health Center at 3205 Defense Terrace in the Abbottsford Public Housing Project. These four units were originally tenant apartments. Medicare Reimbursement Manual HIM 15-1 Section 1000 to 1011.7 supports RHD's contention that PHA had control over RHD's operation and was also a partner. PHA's ownership and maintenance provides essential control of the FQHC site. HUD requires the housing authority (PHA) to provide access to quality of life services to its owners and tenants especially health care resources (Exhibits 11, 12, 13, 15, &17). Partnering with RHD allowed PHA to satisfy the HUD's health care quality of life service goals.

Other related party elements are listed below:

1) RHD was one of seven FQHCs in 1991 to receive the first Section 330 (i) public housing grant (PHPHC). HRSA requires a Housing Authority partnership at the time and for every year thereafter (Exhibit 7).

2) Philadelphia Housing Authority is a collaborating partner in RHD's HRSA Health Care PHPC mission as noted in Exhibit 7, also in the annual grant applications (e.g. FY 2008 Grant Exhibit 16) and on their website for on-site clinics (Exhibit 11).

3) Philadelphia Housing Authority (PHA) is a corporate body, public & political corporation, chartered to provide safe, sanitary, decent housing for families of low income. The federal aided program of the Housing Authority was authorized under the federal Housing Act of 1937 and 1940, and by a "cooperation agreement" of 1950 with the City of Philadelphia and the Philadelphia Board of Education. Legal Authority References are: PA Statute Title 35 section 154.1 and US Federal Statute Title 42 section 1437. PHA is part of the executive branch of the Commonwealth of PA. PHA granted RHD access to their housing patients and allowed RHD's Health Center to be located in four apartment units. PHA is a PA governmental agency. These facts were confirmed by Mr. Virginus Bragg, PHA Compliance officer-(office # 215-684-4295) (Exhibits 14).

4) HRSA requires that each state Department of Health must approved a Section 330 (i) grantee. There must be a collaborative public housing partner as noted throughout the HRSA grant requirements (Exhibit 7).

5) RHD paid for housekeeping, telephone, for building and general liability insurance. RHD also provided major building improvements and expansions, up to FY2007. RHD also paid for some utilities cost to the PHA for Schuylkill Falls.

Utility payments were made to the AHTMC for Abbottsford – not to PHA and not for Schuylkill Falls.

6) RHD and the Abbottsford Home Tenant Management Corporation (AHTMC) entered into a memo of understanding to operate the Abbottsford health center for three year grant periods in 1993 (Exhibit 8) and later in 1995 (Exhibit 24). The AHTMC/RHD management committee controls and manages the business and affairs of the Health Center (Exhibits 8 & 24). The AHTMC/RHD management committee was composed of 4 AHTMC tenants and 3 RHD appointees. The AHTMC tenants had a majority control of the FQHC's board. Majority controls make the AHTMC, a related party, and any cost paid for Abbottsford Health Center expense can be included.

7). RHD and the Schuylkill Falls Tenant Council (SFTC) entered into a memo of understanding to operate the Schuylkill Falls health center for three year grant periods in 1995 (Exhibit 24). The SFTC/RHD management committee controls and manages the business and affairs of the Health Center (Exhibits 24). The SFTC/AHTMC/RHD management committee was composed of 10 appointees; 4 ATHMC tenants, 3 SFTC Tenants and 3 RHD appointees. The housing tenants had a majority control of the FQHC's board especially from the health center building aspect. The majority tenant controls makes the AHTMC/SFTC a related party, and any health care center cost paid for the tenant council can be included in the cost report.

9) We believe that PHA paid the rent expense for both buildings (cost of space-depreciation and interest) and the Schuylkill Falls utilities as part of the collaborative partnership, using HUD funds or Tenant council payments.

10) PHA license Agreement with RHD was signed for the Schuylkill Falls Health Center. Refer to a sample PHA agreement (Exhibit 23).

11) PHA paid for these expenses from HUD operating funds, and HUD construction financing funds and loans.

**In summary, we believe there is enough evidence and facts displaying that PHA and its tenant councils are a related party which allows their cost to be used as a RHD's reimbursable expenses. RHD has elected to record the PHA tenants/owners cost as the RHD's allowable cost. PHA's actual facility cost would be substantially higher than the tenants/owners cost.**

### **Second Argument for Rent and Utility Allowable Cost**

**PHA is a Quasi-Governmental Agency under HIM 27 Section 433.3B which allows FQHC's Medicare and Medicaid reimbursement for allowable cost related to patient services. Governmental Agency payment must be for FQHC allowable cost (Exhibit 18) .**

PHA's payments for the cost of the health center space and utilities, is also allowable as a reimbursable cost since PHA is a governmental agency. A governmental statutory exclusion in the RHC/FQHC manual HIM 27 SEC 433.3.B allows governmental payments to FQHCs as a reimbursable cost (Exhibit 18). Under governmental accounting rules, services can't be donated by a government or governmental officials or governmental agency. Governments have to provide grants (restricted) and/or appropriations (general funds) to grantees or taxpayers. They are based on laws passed or administrative power within the executive branches of government.

**The FQHCs have a statutory exclusion which the Medicare and Medicaid program allows FQHC reimbursement for governmental grants and appropriations. The cost must be for allowable and necessary services under Medicare reasonable cost section (PRM 1 sections 2100) (Exhibit 21). Both the cost of space and utilities were necessary facility services for the Medicaid and Medicare beneficiaries. RHD believes that PHA is a governmental agency that qualifies under the FQHC statutory exclusion. Therefore, any allowable and necessary cost paid by the PHA government agency or granted to the FQHC would be allowable under the Medicare and Medicaid programs.**

Discussion of 433.3 B statutory exclusion- Payment was not for services to beneficiaries

#### **DPW Auditors Argument**

The audit conclusion to disallow the imputed amounts is based on the fact that nothing was *paid*. Also, even if there were amounts paid for rent, the payments were not "*...for services to beneficiaries...*" Rather, the payments, even if they were made, would have been for facilities provided to the FQHC. As such, the citation advanced by RHD is inapplicable. HIM-15, Section 610 controls and directs that the value of donated space should be deleted from the cost report.

Finally, it should be noted that the imputed amounts were not recorded in RHD's books and records. Instead, these amounts were for purposes of the Cost Reports only.

#### **RHD's Argument**

PHA is RHD's partner in treating the low income housing population plus it is a governmental agency which is using HUD's funds to pay for these two reasonable and necessary expenses. Every expense recorded on the cost report is for services to the beneficiaries. Most of the expenses are reimbursable based on the type of costs-medical, facility, & administrative. A beneficiary is treated in a FQHC facility and therefore the facility cost is benefiting the patient. Not all cost have to be directly related to personal patient health care services. If the FQHC or a government agency (local, state, federal or quasi) pays for these

costs, the expenses are reimbursable. RHD's transaction with PHA is a true example of the FQHC statutory cost exception. RHD corporate offices agree that they should be recording the related party transactions (Non-Profit Org. GAAP principles) on their books. During their base year periods, the dollar amount involved was not material enough to record on the corporate financial statements. On the other hand, the amount is material to RHD-FQHC division and was reported on the cost report as a reimbursable.

The PA Medicaid program does not have a protested cost report line so the FQHC must report the expense on the cost report in order to protect the FQHC appeal rights.

### **Third Argument for Rent and Utility Allowable Cost**

**PHA and/or Public Housing Tenant Councils are providing restricted grants for specific expenses which are covered under HIM 15-1 Section 600 as reimbursable expenses.**

PHA payments could also be deemed a restricted grant since it is paying specific costs such as facility and utility expenses. Medicare HIM 15-1 Section 600 (Exhibit 22) reads as follows: Grants, gifts, or endowment income designated by a donor for paying specific operating costs for cost reporting periods beginning before October 1, 1983, should be deducted from the particular operating cost or group of costs. Restricted grants, gifts, and income from endowments designated for cost reporting periods beginning October 1, 1983, should not be deducted from the particular operating costs or group of costs.

**After October 1, 1983, all restricted grants do not have to be offset against expenses. If the PHA payments are considered a grant, the cost would not have to be offset against costs.**

### **Conclusion**

We look forward to resolving this facility cost issue especially since this issue was reopened after the 1998 DPW review. Ten years have elapsed since the building (rent and utility expenses) related cost was originally approved. Had the 1998 DPW audit proposed BFO's current position for the facility cost, RHD could have made a different decision? As a case and point, PHA's decision on rebuilding Schuylkill Falls and renovating the Abbottsford Housing projects, allowed RHD to decide on moving and renovating its own new site in 2006. RHD new site is accessible to the Abbottsford tenants and has transportation accessible for the Schuylkill Falls tenants. The three stated arguments support RHD contentions that PHA was paying for these building related expenses. PHA is a government agency and PHA is a related party in the facility cost transaction. It could be deemed that PHA and its tenant councils were providing a restricted grant to RHD as a HUD sub recipient. In conclusion, we believe RHD facility

costs are very reasonable, were paid by a related governmental agency and meet Medicare and Medicaid cost reimbursement requirements.

We have also included Exhibit 21 which further discusses Medicare and Medicaid related party transaction specific to RHD's PHA facility transactions.

**Finding No. 4 The Allocation of Administrative Overhead Cost was overstated.**

RHD's Response

We reviewed the overhead allocation and agree with the proposed adjustments

**Finding No. 5 Fines and Unidentified Expenditures were disallowed.**

RHD's Response:

We reviewed the findings and agree with the proposed adjustments.

Exhibits

1. IRS Publication 15-B Employer's Tax Guide Fringe Benefits-De Minimis Benefits & meals (5 pages 8, 14, 15 & 16)
2. Medicare Reimbursement Manual HIM-15-1 Sections 2144 Fringe Benefits & 2145 Employee Personnel Meal Cost
3. Field Audit Write-up for Employee Meal Expenses ( 4 pages)
4. PA Code for Minimum Standards-Requirements for Construction and Equipment for Hospital and Medical Facilities
5. 1996-1997 Guideline for design and Construction of Hospital and Health Care Facilities (3 pages)
6. Medicare Reimbursement Manual Section 1000.0 to 1011.7 Related Party Organization (11 pages)
7. HRSA's Public Housing Health Center Mission-(PHPC)
8. Memo of Understanding between Abbotsford Homes Tenant Management Corporation (AHTMC) and RHD effective (8 pages)
9. Sample PHA/AHTMC invoice for Rent, Utilities and Housekeeping
10. PHA 's Tenant Support Services, Inc. (TSSI) website
11. PHA's On-site Clinics website
12. HUD's Strategic Goal C 2006-2011- Strengthen Communities (4 pages) Health Care Goals Noted (4 pages)
13. HUD's Interagency Partnership goals- (5 pages)-health care goals noted
14. PHA-Website home & Agency History ( 6 pages)
15. HUD Linking Residents to Health Resources (10 pages)
16. FY 2008 HRSA renewal grant reference to a PHA Collaborative Network (3 Pages)
17. HUD's creating a Health program at your Center (4 pages)

18. HIM 27 RHC/FQHC Manual section 433.3 B Items and services furnished or paid for by government instrumentalities and are furnished by a RHC or an FQHC (2 pages)
19. Imputed Rent and Utilities cost for Abbottsford & Falls Health Centers
20. Martin Luther King Budget construction cost FY 2006 (2 pages)
21. Medicare Related Organization and further discussions on RHD facility cost (4 pages)
22. Medicare HIM 15-1 Section 600 & 606-Restricted grants
23. PHA License Agreement with for Schuylkill Falls Health Center (7/1/1997) (13 pages)
24. Memo of Understanding between Abbottsford Homes Tenant Management Corporation (AHTMC), Schuylkill Falls Tenant Council (SFTC) and RHD effective August 1995 (8 pages)
25. Former PHA Executive, Tine Hansen-Turton, MGA, JD Resume(4 pages)

Website references

EXH 12 <http://www.hud.gov/offices/cfo/stratplan.cfm>

EXH 14 <http://www.hud.gov/offices/hsg/mfh/nnw/health.pdf>

EXG 14 <http://www.phila.gov/phils/Docs/Inventor/Graphics/agencies/A152.htm>

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23. PHA License Agreement-sample ( Pages)

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EXG 14 <http://www.phila.gov/phils/Docs/Inventor/Graphics/agencies/A152.htm>

- A current employee.
- A former employee who retired or left on disability.
- A widow or widower of an individual who died while an employee.
- A widow or widower of a former employee who retired or left on disability.
- A leased employee who has provided services to you on a substantially full-time basis for at least a year if the services are performed under your primary direction or control.
- A partner who performs services for a partnership.

## De Minimis (Minimal) Benefits

You can exclude the value of a de minimis benefit you provide to an employee from the employee's wages. A de minimis benefit is any property or service you provide to an employee that has so little value (taking into account how frequently you provide similar benefits to your employees) that accounting for it would be unreasonable or administratively impracticable. Cash and cash equivalent fringe benefits (for example, use of gift card, charge card, or credit card), no matter how little, are never excludable as a de minimis benefit, except for occasional meal money or transportation fare.

Examples of de minimis benefits include the following.

- Occasional personal use of a company copying machine if you sufficiently control its use so that at least 85% of its use is for business purposes.
- Holiday gifts, other than cash, with a low fair market value.
- Group-term life insurance payable on the death of an employee's spouse or dependent if the face amount is not more than \$2,000.
- Meals. See *Meals*, later.
- Occasional parties or picnics for employees and their guests.
- Occasional tickets for entertainment or sporting events.
- Transportation fare. See *Transportation (Commuting) Benefits*, later.

**Employee.** For this exclusion, treat any recipient of a de minimis benefit as an employee.

## Dependent Care Assistance

This exclusion applies to household and dependent care services you directly or indirectly pay for or provide to an employee under a dependent care assistance program that covers only your employees. The services must be for a qualifying person's care and must be provided to allow the employee to work. These requirements are basically

the same as the tests the employee would have to meet to claim the dependent care credit if the employee paid for the services. For more information, see *Qualifying Person Test* and *Work-Related Expense Test* in Publication 503, *Child and Dependent Care Expenses*.

**Employee.** For this exclusion, treat the following individuals as employees.

- A current employee.
- A leased employee who has provided services to you on a substantially full-time basis for at least a year if the services are performed under your primary direction or control.
- Yourself (if you are a sole proprietor).
- A partner who performs services for a partnership.

**Exclusion from wages.** You can exclude the value of benefits you provide to an employee under a dependent care assistance program from the employee's wages if you reasonably believe that the employee can exclude the benefits from gross income.

An employee can generally exclude from gross income up to \$5,000 of benefits received under a dependent care assistance program each year. This limit is reduced to \$2,500 for married employees filing separate returns.

However, the exclusion cannot be more than the earned income of either:

- The employee, or
- The employee's spouse.

Special rules apply to determine the earned income of a spouse who is either a student or not able to care for himself or herself. For more information on the earned income limit, see Publication 503.

**Exception for highly compensated employees.** You cannot exclude dependent care assistance from the wages of a highly compensated employee unless the benefits provided under the program do not favor highly compensated employees and the program meets the requirements described in section 129(d) of the Internal Revenue Code.

For this exclusion, a highly compensated employee for 2007 is an employee who meets either of the following tests.

1. The employee was a 5% owner at any time during the year or the preceding year.
2. The employee received more than \$100,000 in pay for the preceding year.

You can choose to ignore test (2) if the employee was not also in the top 20% of employees when ranked by pay for the preceding year.

**Form W-2.** Report the value of all dependent care assistance you provide to an employee under a dependent care assistance program in box 10 of the employee's Form W-2. Include any amounts you cannot exclude from the employee's wages in boxes 1, 3, and 5.



Department of the Treasury  
Internal Revenue Service

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# Employer's Tax Guide to Fringe Benefits

## For Benefits Provided in 2007



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### What's New

**Cents-per-mile rule.** The standard mileage rate you can use under the cents-per-mile rule to value the personal use of a vehicle you provide to an employee in 2007 is 48.5 cents a mile. See *Cents-Per-Mile Rule* in section 3.

**Increase in qualified parking exclusion and commuter transportation benefit.** For 2007, the monthly exclusion for qualified parking increases to \$215 and the monthly exclusion for commuter highway vehicle transportation and transit passes increases to \$110. See *Qualified Transportation Benefits* in section 2.

Exhibit 1

Different tests may apply to lodging furnished by educational institutions. See section 119(d) of the Internal Revenue Code for details.

The exclusion does not apply if you allow your employee to choose to receive additional pay instead of lodging.

**On your business premises.** For this exclusion, your business premises is generally your employee's place of work. (For special rules that apply to lodging furnished in a camp located in a foreign country, see section 119(c) of the Internal Revenue Code and its regulations.)

**For your convenience.** Whether or not you furnish lodging for your convenience as an employer depends on all the facts and circumstances. You furnish the lodging to your employee for your convenience if you do this for a substantial business reason other than to provide the employee with additional pay. This is true even if a law or an employment contract provides that the lodging is furnished as pay. However, a written statement that the lodging is furnished for your convenience is not sufficient.

**Condition of employment.** Lodging meets this test if you require your employees to accept the lodging because they need to live on your business premises to be able to properly perform their duties. Examples include employees who must be available at all times and employees who could not perform their required duties without being furnished the lodging.

It does not matter whether you must furnish the lodging as pay under the terms of an employment contract or a law fixing the terms of employment.

**Example.** A hospital gives Joan, an employee of the hospital, the choice of living at the hospital free of charge or living elsewhere and receiving a cash allowance in addition to her regular salary. If Joan chooses to live at the hospital, the hospital cannot exclude the value of the lodging from her wages because she is not required to live at the hospital to properly perform the duties of her employment.

**S corporation shareholders.** For this exclusion, do not treat a 2% shareholder of an S corporation as an employee of the corporation. A 2% shareholder is someone who directly or indirectly owns (at any time during the year) more than 2% of the corporation's stock or stock with more than 2% of the voting power.

## Meals

This section discusses the exclusion rules that apply to de minimis meals and meals on your business premises.

### De Minimis Meals

You can exclude any meal or meal money you provide to an employee if it has so little value (taking into account how frequently you provide meals to your employees) that accounting for it would be unreasonable or administratively impracticable. The exclusion applies, for example, to the following items.

- Coffee, doughnuts, or soft drinks.

- Occasional meals or meal money provided to enable an employee to work overtime. (However, the exclusion does not apply to meal money figured on the basis of hours worked.)
- Occasional parties or picnics for employees and their guests.

This exclusion also applies to meals you provide at an employer-operated eating facility for employees if the annual revenue from the facility equals or exceeds the direct costs of the facility. For this purpose, your revenue from providing a meal is considered equal to the facility's direct operating costs to provide that meal if its value can be excluded from an employee's wages as explained under *Meals on Your Business Premises* later.



*If food or beverages you furnish to employees qualify as a de minimis benefit, you can deduct their full cost. The 50% limit on deductions for the cost of meals does not apply. The deduction limit on meals is discussed in chapter 2 of Publication 535.*

**Employee.** For this exclusion, treat any recipient of a de minimis meal as an employee.

**Employer-operated eating facility for employees.** An employer-operated eating facility for employees is an eating facility that meets all the following conditions.

- You own or lease the facility.
- You operate the facility. (You are considered to operate the eating facility if you have a contract with another to operate it.)
- The facility is on or near your business premises.
- You provide meals (food, drinks, and related services) at the facility during, or immediately before or after, the employee's workday.

**Exclusion from wages.** You can generally exclude the value of de minimis meals you provide to an employee from the employee's wages.

**Exception for highly compensated employees.** You cannot exclude from the wages of a highly compensated employee the value of a meal provided at an employer-operated eating facility that is not available on the same terms to one of the following groups.

- All of your employees.
- A group of employees defined under a reasonable classification you set up that does not favor highly compensated employees.

For this exclusion, a highly compensated employee for 2007 is an employee who meets either of the following tests.

1. The employee was a 5% owner at any time during the year or the preceding year.
2. The employee received more than \$100,000 in pay for the preceding year.

You can choose to ignore test (2) if the employee was not also in the top 20% of employees when ranked by pay for the preceding year.

### Meals on Your Business Premises

You can exclude the value of meals you furnish to an employee from the employee's wages if they meet the following tests.

- They are furnished on your business premises.
- They are furnished for your convenience.

This exclusion does not apply if you allow your employee to choose to receive additional pay instead of meals.

**On your business premises.** Generally, for this exclusion, the employee's place of work is your business premises.

**For your convenience.** Whether you furnish meals for your convenience as an employer depends on all the facts and circumstances. You furnish the meals to your employee for your convenience if you do this for a substantial business reason other than to provide the employee with additional pay. This is true even if a law or an employment contract provides that the meals are furnished as pay. However, a written statement that the meals are furnished for your convenience is not sufficient.

**Meals excluded for all employees if excluded for more than half.** If more than half of your employees who are furnished meals on your business premises are furnished the meals for your convenience, you can treat all meals you furnish to employees on your business premises as furnished for your convenience.

**Food service employees.** Meals you furnish to a restaurant or other food service employee during, or immediately before or after, the employee's working hours are furnished for your convenience. For example, if a waitress works through the breakfast and lunch periods, you can exclude from her wages the value of the breakfast and lunch you furnish in your restaurant for each day she works.

**Example.** You operate a restaurant business. You furnish your employee, Carol, who is a waitress working 7 a.m. to 4 p.m., two meals during each workday. You encourage but do not require Carol to have her breakfast on the business premises before starting work. She must have her lunch on the premises. Since Carol is a food service employee and works during the normal breakfast and lunch periods, you can exclude from her wages the value of her breakfast and lunch.

If you also allow Carol to have meals on your business premises without charge on her days off, you cannot exclude the value of those meals from her wages.

**Employees available for emergency calls.** Meals you furnish during working hours so an employee will be available for emergency calls during the meal period are furnished for your convenience. You must be able to show

these emergency calls have occurred or can reasonably be expected to occur.

**Example.** A hospital maintains a cafeteria on its premises where all of its 230 employees may get meals at no charge during their working hours. The hospital must have 120 of its employees available for emergencies. Each of these 120 employees is, at times, called upon to perform services during the meal period. Although the hospital does not require these employees to remain on the premises, they rarely leave the hospital during their meal period. Since the hospital furnishes meals on its premises to its employees so that more than half of them are available for emergency calls during meal periods, the hospital can exclude the value of these meals from the wages of all of its employees.

**Short meal periods.** Meals you furnish during working hours are furnished for your convenience if the nature of your business restricts an employee to a short meal period (such as 30 or 45 minutes) and the employee cannot be expected to eat elsewhere in such a short time. For example, meals can qualify for this treatment if your peak work-load occurs during the normal lunch hour. However, they do not qualify if the reason for the short meal period is to allow the employee to leave earlier in the day.

**Example.** Frank is a bank teller who works from 9 a.m. to 5 p.m. The bank furnishes his lunch without charge in a cafeteria the bank maintains on its premises. The bank furnishes these meals to Frank to limit his lunch period to 30 minutes, since the bank's peak workload occurs during the normal lunch period. If Frank got his lunch elsewhere, it would take him much longer than 30 minutes and the bank strictly enforces the time limit. The bank can exclude the value of these meals from Frank's wages.

**Proper meals not otherwise available.** Meals you furnish during working hours are furnished for your convenience if the employee could not otherwise eat proper meals within a reasonable period of time. For example, meals can qualify for this treatment if there are insufficient eating facilities near the place of employment.

**Meals after work hours.** Meals you furnish to an employee immediately after working hours are furnished for your convenience if you would have furnished them during working hours for a substantial nonpay business reason but, because of the work duties, they were not eaten during working hours.

**Meals you furnish to promote goodwill, boost morale, or attract prospective employees.** Meals you furnish to promote goodwill, boost morale, or attract prospective employees are not considered furnished for your convenience. However, you may be able to exclude their value as discussed under *De Minimis Meals*, earlier.

**Meals furnished on nonworkdays or with lodging.** You generally cannot exclude from an employee's wages the value of meals you furnish on a day when the employee is not working. However, you can exclude these meals if they are furnished with lodging that is excluded from the

employee's wages as discussed under *Lodging on Your Business Premises*, earlier.

**Meals with a charge.** The fact that you charge for the meals and that your employees may accept or decline the meals is not taken into account in determining whether or not meals are furnished for your convenience.

**S corporation shareholder-employee.** For this exclusion, do not treat a 2% shareholder of an S corporation as an employee of the corporation. A 2% shareholder is someone who directly or indirectly owns (at any time during the year) more than 2% of the corporation's stock or stock with more than 2% of the voting power.

## Moving Expense Reimbursements

This exclusion applies to any amount you directly or indirectly give to an employee, (including services furnished in kind) as payment for, or reimbursement of, moving expenses. You must make the reimbursement under rules similar to those described in chapter 13 of Publication 535 for reimbursement of expenses for travel, meals, and entertainment under accountable plans.

The exclusion applies only to reimbursement of moving expenses that the employee could deduct if he or she had paid or incurred them without reimbursement. However, it does not apply if the employee actually deducted the expenses in a previous year.

**Deductible moving expenses.** Deductible moving expenses include only the reasonable expenses of:

- Moving household goods and personal effects from the former home to the new home, and
- Traveling (including lodging) from the former home to the new home.

Deductible moving expenses do not include any expenses for meals and must meet both the distance test and the time test. The distance test is met if the new job location is at least 50 miles farther from the employee's old home than the old job location was. The time test is met if the employee works at least 39 weeks during the first 12 months after arriving in the general area of the new job location.

For more information on deductible moving expenses, see Publication 521, *Moving Expenses*.

**Employee.** For this exclusion, treat the following individuals as employees.

- A current employee.
- A leased employee who has provided services to you on a substantially full-time basis for at least a year if the services are performed under your primary direction or control.

**Exception for S corporation shareholders.** Do not treat a 2% shareholder of an S corporation as an employee of the corporation for this purpose. A 2% shareholder is

someone who directly or indirectly owns (at any time during the year) more than 2% of the corporation's stock or stock with more than 2% of the voting power.

**Exclusion from wages.** Generally, you can exclude qualifying moving expense reimbursement you provide to an employee from the employee's wages. If you paid the reimbursement directly to the employee, report the amount in box 12 of Form W-2 with the code P. Do not report payments to a third party for the employee's moving expenses or the value of moving services you provided in kind.

## No-Additional-Cost Services

This exclusion applies to a service you provide to an employee if it does not cause you to incur any substantial additional costs. The service must be offered to customers in the ordinary course of the line of business in which the employee performs substantial services.

Generally, no-additional-cost services are excess capacity services, such as airline, bus, or train tickets; hotel rooms; or telephone services provided free or at a reduced price to employees working in those lines of business.

**Substantial additional costs.** To determine whether you incur substantial additional costs to provide a service to an employee, count any lost revenue as a cost. Do not reduce the costs you incur by any amount the employee pays for the service. You are considered to incur substantial additional costs if you or your employees spend a substantial amount of time in providing the service, even if the time spent would otherwise be idle or if the services are provided outside normal business hours.

**Reciprocal agreements.** A no-additional-cost service provided to your employee by an unrelated employer may qualify as a no-additional-cost service if all the following tests are met:

- The service is the same type of service generally provided to customers in both the line of business in which the employee works and the line of business in which the service is provided.
- You and the employer providing the service have a written reciprocal agreement under which a group of employees of each employer, all of whom perform substantial services in the same line of business, may receive no-additional-cost services from the other employer.
- Neither you nor the other employer incurs any substantial additional cost either in providing the service or because of the written agreement.

**Employee.** For this exclusion, treat the following individuals as employees.

1. A current employee.
2. A former employee who retired or left on disability.
3. A widow or widower of an individual who died while an employee.

**HIM 15-1 Medicare Reimbursement Manual  
2144-Fringe Benefits & 2145-Employee Personnel Meal Cost**

**2144.3 Requirements for Recognition of Fringe Benefits.**--The costs of fringe benefits must be reasonable, as defined in §2102.1, and related to patient care, as defined in §2102.2.

**2144.4 Fringe Benefits Includable as Provider's Cost.**--Following are examples of fringe benefits:

- o Provider contributions to certain deferred compensation plans (see §2140ff);
- o Provider contributions to certain pension plans (see §2142ff);
- o Paid vacation (see §2146), paid holidays, sick leave (see §2144.8), all-inclusive paid days off (see §2144.9), voting leave, court or jury duty leave, all of which generally are included in employee earnings;
- o Provider-paid educational courses benefiting the employee's interest;
- o Provider's unrecovered cost of meals (see §2145) and room and board furnished employees for the employees' convenience;
- o Provider's unrecovered cost of medical services rendered to employees (see §332.1); and
- o Cost of health and life insurance premiums paid or incurred by the provider if the benefits of the policy inure to the employee or his/her beneficiary.

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2144.5

**COSTS RELATED TO PATIENT CARE**

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**2145. Cost of Meals for Provider Personnel.**--Any reasonable unrecovered cost of a provider's personnel meals is allowable when deemed a fringe benefit (see §2144.4E) related to patient care. Also, any reasonable unrecovered cost of a provider's personnel meals when deemed solely for the provider's benefit and related to patient care is allowable under the principle in §2102.2. An example of the latter is the cost of meals served to selected personnel who must remain on call to provide patient care on the provider's premises during mealtime and the cost of the meals is not deemed a fringe benefit.

Where a provider maintains multiple food services, e.g., a coffee shop or restaurant, in addition to a food service facility for provider personnel, and the additional food services are determined to be unnecessary for such personnel, the applicable unrecovered cost is unallowable. Some conditions under which the additional food services may be determined as necessary are the following:

1. The provider personnel food service facility (e.g., personnel cafeteria) has the capacity for serving all provider personnel meals;
2. It would be economically feasible to extend the hours of the personnel food service facility to serve meals to provider personnel on another work shift;

Exhibit 2

4/8/2008 wet RHD Field audit

### **Allowable Employee Cafeteria Meal Cost**

(DPW proposed disallowance of the coffee and meeting meals on the FQHC premises)

FQHCs are Medicare Part A Facility Providers. They are similar to Hospitals and Nursing Homes which allow the reasonable cost of meals served to employees as a fringe benefit (HIM 15-1 Section 2144 & 2145) and thus are related to the care of patients. Most hospitals (who also have clinics) subsidize their cafeteria cost using discounted employee pricing and charge visitors full price. This practice has long been accepted in the health care industry since hospitals need to keep their employees in the building to be close to their patients. Interns/residents typically receive free meals while in the hospital.

Hospitals usually have departmental meetings with staff in designated hospital conference rooms to discuss patient care, operational and administrative policies. At these meetings, coffee, drinks, donuts and sandwiches are served during early morning and lunch time meetings.

The food and service cost of these meals are the employee fringe benefits covered by Medicare 15-1 section 2144 & 2145 and under the IRS Pub 15-B Employee Tax Guide to Fringe Benefits-2007. These meal benefits are excluded from taxes. The reference meals sections of IRS Publication 15-B are presented below:

Meals (IRS- Pub 15-2007 Page 14)

This section discusses the fringe benefit exclusion rules that apply to de minimis meals and meals on your business premises.

#### **De Minimis Meals**

You can exclude any meal or meal money you provide to an employee if it has so little value (taking into account how frequently you provide meals to your employees) that accounting for it would be unreasonable, or administratively impracticable. The exclusion applies, for example, to the following items.

- Coffee, doughnuts, or soft drinks.
- Occasional meal money provided to enable an employee to work overtime.
- Occasional parties or picnics for employees and their guests.

The 50% limit on business deductions for the cost of the meals does not apply.

**Employee.** For this exclusion, treat any recipient of a de minimis meal as a employee.

#### **Employer-Operated Eating Facility for Employees**

Exhibit 3

An employer—operating eating facility for employees is an eating facility that meets all of the following conditions:

- You own or lease the facility.
- You operate the facility (or you have a contract with another to operate it).
- The facility is on or near the facility.
- You provide meals (food, drinks, and related services) at the facility during, or immediately before or after, the employee's workday.

**Exclusion From wages:** You can generally exclude the value of the de minimis meals you provide to an employee from the employee's wages.

### **Meals on your Business Premises**

You can exclude the value of meals you furnish to an employee's wages if they meet the following tests.

- They are furnished on the business premises.
- They are furnished for your (Employer) convenience.

**On your business premises.** Generally, for this exclusion, the employee's place of work is your business premises.

### **For Your Convenience**

Whether you furnish meals for your convenience as an employer depends on all of the facts and circumstances. You furnish the meals to employees for your convenience if you do this for a substantial business reason other than to provide an employee with additional pay.

**Example.** A Hospital maintains a cafeteria on its premises where all of the 230 employees may receive meals at no charge during their working hours. The hospital must have 120 of its employees available for emergencies. Each of the 120 of its employees is, at times, called upon to perform services during the meal period. Although the hospital does not require these employees to remain on the premises, they rarely leave the hospital during their meal period. Since the hospital furnishes meals on its premises to its employees so that more than half of them are available for emergency calls during meal periods. The hospital can exclude the value of these meals from the wages of all of its employees.

**Short meal periods.** Meals you furnish during working hours are furnished for your convenience if the nature of business restricts an employee to a short meal period (such as 30 or 45 minutes) and the employee cannot be expected to eat elsewhere in such a short time. For example, meals can qualify for this treatment if peak work-load occurs

during the normal lunch hour. However, they do not qualify if the reason for the short meal period is to allow the employee to leave earlier in the day.

### **Proper Meals not otherwise available**

#### **RHD Food and meals cost 99-G & OO-H**

RHD has 27 Staff during FY 1999 & 2000.

RHD food cost covers 2 FQHC facilities and a administrative office. All of the sites are located in medically underserved urban areas of Philadelphia which also has high crime rate. Employees usually bring their own lunch or order for lunch deliveries. The FQHC sites have employee dining areas as required by Health Care Ambulatory Care Facilities Standards (JACHO).

RHD does not provide breakfast, lunch or dinner meals to any employees.

RHD does occasionally provide doughnuts, coffee, meals and drinks during internal meetings which are either before patient hours, at lunch time or after patient hours.

Lunch time hours, meetings could be for RXs refill approval, patient call backs, positive test results calls, scheduling, etc. While most employee bring their lunch every day, staff could occasionally have full lunch usually only for administrative meetings or training meetings. This is a short meal period.

Meetings at the corporate office may have provided lunch if the providers or staff have to get back to the facilities.

Board meeting meals (sandwiches & snacks) are provided for each meeting. FQHC boards are required to have a periodic meetings and are responsible for overall corporate authority and oversight of the FQHC.

Annual Holiday party for employees is held each year and is allowable under the De minimis meals section.

Again, under both the IRS and Medicare regulations, food cost, is for the convenience of the FQHC employer to keep the staff on the premises. Like most physician practices, the staff is working before patient hours and during lunch time to handle patient's calls, medical issues, and internal administrative meetings.

The employee are not charged for drinks or meals and patients are not allowed in the employee dining areas. Vending machines are located in the employee dining area and

are allowable cost less any revenue received. We offset the vending machine revenues against cost.

We believe the RHD's food cost is allowable, relates to patient care, reasonable and provided convenience under the Medicare Principles and IRS pub 15-B Employee Meals rules.

Since the PA Medicaid manual did not address employee meals on the FQHC premises, the Medicare & the IRS regulations take precedence. Only the common area vending machines, gift shop service and telephone expenses are addressed in the Appendix E-Section Non-Compensable Section U and we have offset any related miscellaneous Section U income against cost.

We had no common areas such as  
Vending machines  
Gift or Snack Shop  
Paid Telephone Station

Attachments

IRS Publication 15 B-Employer's tax guide to fringe benefits-2007  
Page 8, 14 & 15

Medicare HIM 15-1 Section 2144 & 2145

Ex H, 6, 7 3

**§ 153.1. Minimum standards.**

(a) Hospital construction shall be in accordance with the standards set forth in the latest edition of the Department of Health and Human Services handbook, *Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities*, DHHS Publication No. (HRA) 14500 Regulations, published under Title VI of the Public Health Service Act (42 U.S.C. § § 291—291 o-1) and referred to as "HHS Requirements," except as modified in this chapter.

(b) Hospitals previously in compliance with prior editions of Department of Health and Human Services handbook, *Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities*, DHHS Publication No. (HRA) 14500 Regulations, will be deemed in compliance with any subsequent regulations with the exception of any new renovations or construction, which shall meet the current edition.

(c) A hospital shall meet the edition of the National Fire Protection Association 101, Life Safety Code and all applicable appendices which are currently enforced by the Federal government. Hospitals previously in compliance with prior editions of the Life Safety Code will be deemed in compliance with any subsequent codes with the exception of any new renovation or construction, which shall meet the current edition.

**Authority**

The provisions of this § 153.1 issued under 67 Pa.C.S. § § 6101—6104; and Reorganization Plan No. 2 of 1973 (71 P. S. § 755-2).

**Source**

The provisions of this § 153.1 amended through January 20, 1984, effective January 21, 1984, 14 Pa.B. 215. Immediately preceding text appears at serial pages (77321) to (77322).

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RA 967 .G84 1996-7

1996-97

GUIDELINES FOR  
DESIGN AND  
CONSTRUCTION OF

# HOSPITAL AND HEALTH CARE FACILITIES

■ The American Institute of Architects Academy  
of Architecture for Health with assistance from  
the U.S. Department of Health and Human Services

The American Institute of Architects Press  
WASHINGTON, D.C.

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Ex H. 6. T 5

## 9.2 Common Elements for Outpatient Facilities

The following shall apply to each outpatient facility described herein with additions and/or modifications as noted for each specific type. Special consideration shall be given to needs of children for pediatric services.

### 9.2.A. Administration and Public Areas

**9.2.A1. Entrance.** Located at grade level and able to accommodate wheelchairs.

**9.2.A2. Public services shall include:**

- a. Conveniently accessible wheelchair storage.
- b. A reception and information counter or desk.
- c. Waiting space(s). Where an organized pediatric service is part of the outpatient facility, provisions shall be made for separating pediatric and adult patients.
- d. Conveniently accessible public toilets.
- e. Conveniently accessible public telephone(s).
- f. Conveniently accessible drinking fountain(s).

**9.2.A3. Interview space(s)** for private interviews related to social service, credit, etc., shall be provided.

**9.2.A4. General or individual office(s)** for business transactions, records, administrative, and professional staffs shall be provided.

**9.2.A5. Clerical space or rooms** for typing, clerical work, and filing, separated from public areas for confidentiality, shall be provided.

**9.2.A6. Multipurpose room(s)** equipped for visual aids shall be provided for conferences, meetings, and health education purposes.

**9.2.A7. Special storage** for staff personal effects with locking drawers or cabinets (may be individual desks or cabinets) shall be provided. Such storage shall be near individual workstations and staff controlled.

**9.2.A8. General storage facilities** for supplies and equipment shall be provided as needed for continuing operation.

### 9.2.B. Clinical Facilities

As needed, the following elements shall be provided for clinical services to satisfy the functional program:

**9.2.B1. General-purpose examination room(s).** For medical, obstetrical, and similar examinations, rooms shall have a minimum floor area of 80 square feet (7.43 square meters), excluding vestibules, toilets, and closets. Room

arrangement should permit at least 2 feet 8 inches (81.28 centimeters) clearance at each side and at the foot of the examination table. A handwashing fixture and a counter or shelf space for writing shall be provided.

**9.2.B2. Special-purpose examination rooms.** Rooms for special clinics such as eye, ear, nose, and throat examinations, if provided, shall be designed and outfitted to accommodate procedures and equipment used. A handwashing fixture and a counter or shelf space for writing shall be provided.

**9.2.B3. Treatment room(s).** Rooms for minor surgical and cast procedures (if provided) shall have a minimum floor area of 120 square feet (11.15 square meters), excluding vestibule, toilet, and closets. The minimum room dimension shall be 10 feet (3.05 meters). A handwashing fixture and a counter or shelf for writing shall be provided.

**9.2.B4. Observation room(s).** Observation rooms for the isolation of suspect or disturbed patients shall have a minimum floor area of 80 square feet (7.43 square meters) and shall be convenient to a nurse or control station. This is to permit close observation of patients and to minimize possibilities of patients' hiding, escape, injury, or suicide. An examination room may be modified to accommodate this function. A toilet room with lavatory should be immediately accessible.

**9.2.B5. Nurses station(s).** A work counter, communication system, space for supplies, and provisions for charting shall be provided.

**9.2.B6. Drug distribution station.** This may be a part of the nurses station and shall include a work counter, sink, refrigerator, and locked storage for biologicals and drugs.

**9.2.B7. Clean storage.** A separate room or closet for storing clean and sterile supplies shall be provided. This storage shall be in addition to that of cabinets and shelves.

**9.2.B8. Soiled holding.** Provisions shall be made for separate collection, storage, and disposal of soiled materials.

**9.2.B9. Sterilizing facilities.** A system for sterilizing equipment and supplies shall be provided. Sterilizing procedures may be done on- or off-site, or disposables may be used to satisfy functional needs.

**9.2.B10. Wheelchair storage space.** Such storage shall be out of the direct line of traffic.

**9.3.C. Administrative Services**

Each outpatient facility shall make provisions to support administrative activities, filing, and clerical work as appropriate. (See also Section 9.2.A.) Service areas shall include:

**9.3.C1.** Office(s), separate and enclosed, with provisions for privacy.

**9.3.C2.** Clerical space or rooms for typing and clerical work separated from public areas to ensure confidentiality.

**9.3.C3.** Filing cabinets and storage for the safe and secure storage of patient records with provisions for ready retrieval.

**9.3.C4.** Office supply storage (closets or cabinets) within or convenient to administrative services.

**9.3.C5.** A staff toilet and lounge in addition to and separate from public and patient facilities.

**9.3.C6.** Multiuse rooms for conferences, meetings, and health education. One room may be primarily for staff use but also available for public access as needed. In smaller facilities the room may also serve for consultation, etc.

**9.3.D. Public Areas**

Public areas shall be situated for convenient access and designed to promote prompt accommodation of patient needs, with consideration for personal dignity.

**9.3.D1.** Entrances shall be well marked and at grade level. Where entrance lobby and/or elevators are shared with other tenants, travel to the outpatient unit shall be direct and accessible to the disabled. Except for passage through common doors, lobbies, or elevator stations, patients shall not be required to go through other occupied areas or outpatient service areas. Entrance shall be convenient to parking and available via public transportation.

**9.3.D2.** A reception and information counter or desk shall be located to provide visual control of the entrance to the outpatient unit, and shall be immediately apparent from that entrance.

**9.3.D3.** The waiting area for patients and escorts shall be under staff control. The seating area shall contain not less than two spaces for each examination and/or treatment room. Where the outpatient unit has a formal pediatrics service, a separate, controlled area for pediatric patients shall be provided. Wheelchairs within the waiting area will be accommodated.

**9.3.D4.** Toilet(s) for public use shall be immediately accessible from the waiting area. In smaller units the toilet may be unisex and also serve for specimen collection.

**9.3.D5.** Drinking fountains shall be available for waiting patients. In shared facilities, drinking fountains may be outside the outpatient area if convenient for use.

**9.3.D6.** A control counter (may be part of the reception, information, and waiting room control) shall have access to patient files and records for scheduling of services.

**9.3.E. Diagnostic**

Provisions shall be made for X-ray and laboratory procedures as described in Sections 9.2.C and D. Services may be shared or provided by contract off-site. Each outpatient unit shall have appropriate facilities for storage and refrigeration of blood, urine, and other specimens. All standards set forth in Section 9.31 shall be met.

**\*9.3.F. Clinical Facilities****9.4 Small Primary (Neighborhood) Outpatient Facility****9.4.A. General**

Facilities covered under this section are often contained within existing commercial or residential buildings as "store front" units, but they may also be a small, free-standing, new, or converted structure. The size of these units limits occupancy, thereby minimizing hazards and allowing for less stringent standards. Needed community services can therefore be provided at an affordable cost. The term *small structure* shall be defined as space and equipment serving four or fewer workers at any one time. Meeting all provisions of Section 9.2 for general outpatient facilities is desirable, but limited size and resources may preclude satisfying any but the basic minimums described. This section does not apply to outpatient facilities that are within a hospital, nor is it intended for the larger, more sophisticated units.

**9.4.B. Location**

The small neighborhood center is expected to be especially responsive to communities with limited income. It is essential that it be located for maximum accessibility and convenience. In densely populated areas, many of the patients might walk to services. Where a substantial number of patients rely on public transportation, facility location shall permit convenient access requiring a minimum of transfers.

**9.4.C. Parking**

Not less than one convenient parking space for each staff member on duty at any one time and not less than four spaces for patients shall be provided. Parking requirements may be satisfied with street parking, or by a nearby public parking lot or garage. Where the facility is within a shopping center or similar area, customer spaces may meet parking needs.

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COST TO RELATED ORGANIZATIONS

1004.1

## 1000. PRINCIPLE

Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. (Cross-refer to section 2150ff.)

## 1002. DEFINITIONS

1002.1 Related to the provider means that the provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

1002.2 Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

1002.3 Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

## 1004. DETERMINATION OF COMMON OWNERSHIP OR CONTROL IN THE PROVIDER ORGANIZATION AND SUPPLYING ORGANIZATION

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests of sections 1002.2 and 1002.3 above are met. The following persons are considered immediate family for Medicare program purposes: (1) husband and wife, (2) natural parent, child and sibling, (3) adopted child and adoptive parent, (4) step-parent, step-child, step-sister, and step-brother, (5) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law, (7) grandparent and grandchild.

1004.1 Common Ownership Rule

A determination as to whether an individual (or individuals) or organization possesses significant ownership or equity in the provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be

1004.1 (Cont.) COST TO RELATED ORGANIZATIONS 12-82

made on the basis of the facts and circumstances in each case. This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

1004.2 Examples of Common Ownership

The following examples illustrate the general application of the common ownership rule. The percentages used are for illustrative purposes only and are not intended to prescribe objective rules for determining when significant ownership or equity in an organization exists. Substantially lower percentages could still constitute significant ownership. Such a determination must be made on the basis of the facts and circumstances in each case.

Example No. 1--Direct Ownership

Mr. B owns a 60 percent interest in the provider organization and a 55 percent interest in an organization supplying the provider. The provider and the supplying organization are considered related by common ownership since Mr. B possesses significant ownership in both organizations.

Example No. 2--Dispersion of Ownership

Mr. X owns a 70 percent interest in the provider organization and a 40 percent interest in the supplying organization. The remaining 60 percent interest in the supplying organization is owned in equal amounts by twenty individuals unrelated to Mr. X. Unless the provider can demonstrate to the satisfaction of the intermediary that Mr. X's concentrated ownership interest in the supplying organization is not significant, the organizations are considered related to each other by common ownership.

Example No. 3--Attribution of Ownership

Mr. L owns 20 percent of the outstanding shares of a corporate provider and a 50 percent interest in the supplying organization, a partnership. Ms. L, Mr. L's spouse, owns 30 percent of the outstanding shares of the provider corporation. Because Mr. and Ms. L cumulatively hold 50 percent of the provider and Mr. L owns 50 percent of the supplier, the organizations are considered related by common ownership.

1004.3 Control Rule

The term "control" includes any kind of control, whether or not it is legally enforceable and however it is exercisable or exercised. It is the reality of the control which is decisive, not its form or the mode of its exercise.

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The facts and circumstances in each case must be examined to ascertain whether legal or effective control does, in fact, exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

**1004.4** Examples of Control**Example No. 1 - Administrative Control**

Dr. A is the medical director of a provider, but he does not have an ownership interest in the provider. He is also the president and owner of a supplier organization that provides various therapeutic services primarily to the provider. Under the circumstances described, it will be presumed that Dr. A has the power to influence or direct both the provider and the supplying organization, and that the organizations are related to each other by common control.

**Example No. 2 - Contracts**

Provider M enters into a management contract with XYZ Company. Selected terms of the contract provide as follows: (1) that XYZ Company will replace several key provider employees with employees of XYZ Company; (2) that XYZ Company will make a substantial loan to the provider for working capital purposes with the loan to be evidenced by a demand note; and (3) that XYZ Company owns and leases to the provider the building, fixed equipment and land, and that such lease can only be cancelled by XYZ Company, upon which event XYZ Company would assume all the assets and liabilities of the provider. In this example, while any one individual factor might not constitute significant control, in combination it is clear that XYZ Company has the power significantly to influence or direct the actions or policies of Provider M. Thus, Provider M and XYZ Company are related through control.

**Example No. 3 - Indirect Control**

A construction company builds a facility and leases it to an operating company which becomes a provider. Mr. A owns a 100% interest in the construction company and a 35% interest in the operating company. Mr. B, a key employee of the construction company, owns a 20% interest in the operating company. Under the circumstances described, it will be presumed that Mr. A, as the employer of Mr. B in the construction company, can influence Mr. B's decisions relative to the operation of the provider and that the construction company and the provider are related by common control. (Mr. B would probably not jeopardize his position in the construction company by opposing Mr. A's wishes in the management of the provider.)

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## COST TO RELATED ORGANIZATIONS

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## Example No. 4 - Attribution of Control

Mr. A owns a 60% interest in the provider organization. Mr. A's two sons and wife together own a 100% interest in the organization supplying the provider. Under the circumstances described, it will be presumed that Mr. A has the power to influence and direct the actions of his family relating to the operation of the supplying organization, and that the organizations are related by common control.

## 1005. DETERMINATION OF A RELATED ORGANIZATION'S COSTS

The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, facilities, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself. Therefore, if a cost would be unallowable if incurred by the provider itself, it would be similarly unallowable to the related organization. The principles of reimbursement of provider costs described elsewhere in this manual will generally be followed in determining the reasonableness and allowability of the related organization's costs, except where application of a principle in a nonprovider entity would be clearly inappropriate ( e.g., Chapter 22, Determination of Cost of Services to Beneficiaries; Chapter 23, those portions pertaining to cost finding; Chapter 24, Payments to Providers; Chapter 25, Limitations on Coverage of Costs; and Chapter 26, Lower of Cost or Charges). In situations where the provider is a proprietary organization (as defined in section 1202.4), an allowance of a reasonable return on equity capital invested and used in furnishing services, facilities and supplies to the related provider is includable as an element of the reasonable cost of the related organization. The general rules specified in section 1200ff for inclusion and exclusion of certain assets and liabilities in the computation of equity capital for providers will be similarly applied to the assets and liabilities of the related organization.

The provider must make available to the intermediary when requested adequate documentation to support the costs incurred by the related organization, including, when required, access to the related organization's books and records, attributable to supplies and services furnished to the provider. Such documentation must include an identification of the organization's total costs, the basis of allocation of direct and indirect costs to the provider, and other entities served.

## 1010. EXCEPTION TO THE RELATED ORGANIZATION PRINCIPLE

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the intermediary that the following criteria have been met:

a. The supplying organization is a bona fide separate organization. This means that the supplier is a separate sole proprietorship, partnership, joint venture, association or corporation and not merely an operating division of the provider organization.

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COST TO RELATED ORGANIZATIONS

1010.1

b. A substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization. In determining whether the activities are of similar type, it is important to also consider the scope of the activity. For example, a full service management contract would not be considered the same type of business activity as a minor data processing contract. The requirement that there be an open, competitive market is merely intended to assure that the item supplied has a readily discernible price that is established through arm's-length bargaining by well informed buyers and sellers.

c. The services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by such institutions. This requirement means that institutions such as the provider typically obtain the items of services, facilities, or supplies from outside sources, rather than producing the item internally.

d. The charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies. The phrase "open market" takes the same meaning as "open, competitive market" in b. above.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services, facilities, or supplies are allowable as costs.

1010.1 Examples of Applying the Exception

The exception is intended to cover situations where large quantities of goods and services are supplied to the general public and only incidentally are furnished to related organizations.

Example No. 1

The owner/operator of a drug store is a principal stockholder in the proprietary corporation that operates a skilled nursing facility. The drug store operates as an independent business, serving both the general public and the skilled nursing facility. A substantial amount of the business of the drug store is done with the general public. Skilled nursing facilities customarily do not provide pharmaceutical services with in-house resources. Therefore, the exception to the principle applies and the amounts charged to the provider by the drug store are allowable as costs, not to exceed the amounts charged to the general public or to other institutions for similar services.

## 1010.1 (Cont.)

## COST TO RELATED ORGANIZATIONS

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## Example No. 2

A provider enters into a management contract, the terms of which create a relationship through control as described in section 1004.4 - Example No. 2 above. The management company also has a substantial number of similar contracts with other providers. In this situation, the exception to the principle does not apply because the criterion which requires that a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with unrelated organizations could never be met. Because the nature of the management contract creates the relationship, all other transactions of the same type (i.e., management contracts that create a relationship through control) would create a relationship between the contracting parties. Therefore, it would be impossible to enter into this type of contract with an unrelated entity.

## 1011. SPECIAL APPLICATIONS

1011.1 Contracts Creating Relationship

If a provider and a supplying organization are not related before the execution of a contract, but common ownership or control is created at the time of execution by any means, the supply contract will be treated as having been made between related organizations.

Example: Corporation A, a supplier of management services, is unrelated to Corporation B, a provider. Corporation A executes a contract with Corporation B for the provision of various management services to Corporation B. The terms of the contract are the same as those described in section 1004.4 - Example No. 2 above, thus making the two corporations related by control upon execution of the contract. Corporation B's allowable costs for the management services would be limited to Corporation A's costs of providing the management services.

1011.2 Termination of Relationship

If a provider and a supplier are related by common ownership or control at the time of executing a supply contract, the provider's allowable costs will be governed by the related organization principle throughout the full term of the supply contract, even if the common ownership or control terminates before the end of the contract.

Example: Corporation A owns a building and executes a lease contract with Corporation B, a provider. A single stockholder owns 100% of the capital stock of both corporations. A person unrelated to either corporation buys the stock of Corporation B from the stockholder, thus terminating the relationship of Corporation B and Corporation A. However, until the lease is terminated, Corporation B's allowable costs would be limited to Corporation A's costs of ownership.

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COST TO RELATED ORGANIZATIONS

1011.5

1011.3 Disposal of Assets

Under the cost to related organizations principle, the cost of ownership (depreciation, interest, taxes, etc.) of an asset which is used in the program is includable in the allowable cost of a provider even though it is owned by a related party. Where such an asset is sold or otherwise disposed of (see section 130) by a related organization, any gain or loss realized by the related party must be included in the provider's cost. (See section 132ff.) Likewise, where a provider claims accelerated depreciation on an asset owned by a related organization, and it either terminates participation in the program, or substantially reduces its HI utilization, as explained in section 136.4, the excess depreciation claimed is subject to the recapture provisions of section 136.

1011.4 Purchase of Facilities from Related Organizations

Where a facility is purchased from an organization related to the purchaser by common ownership or control, or where a facility, through purchase, converts from a proprietary to a nonprofit status and the buyer and seller entities are related by common ownership or control, the purchaser's basis for depreciation shall not exceed the seller's basis under the program, as computed in section 114, less accumulated depreciation recognized under the program. Also, accumulated depreciation of the seller under the program shall be considered as incurred by the purchaser for purposes of application of section 132ff.

**Examples:**

A construction company builds a facility for an operating company which becomes a provider. Mr. X owns a 100 percent interest in both organizations. The provider organization and the construction company are considered related; therefore, the construction company's costs of building the facility must be used by the provider as the historical cost of the facility.

The owners of a 200-bed hospital convert their facility to a nonprofit corporation. The owners sell the hospital to a nonprofit corporation under the direction of a board of trustees made up of former owners of the proprietary corporation. Both corporations are considered related organizations; therefore, the asset bases to the nonprofit corporation remain the same as contained in the proprietary corporation's records, and there can be no increase in the book value of such assets.

1011.5 Rental Expenses Paid to a Related Organization

A provider may lease a facility from a related organization within the meaning of the principles of reimbursement. In such case, the rent paid to the lessor by the provider is not allowable as cost. The provider, however, would include in its costs the costs of

1011.5 (Cont.)COST TO RELATED ORGANIZATIONS

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ownership of the facility. Generally, these would be costs such as depreciation (subject to the principles in Chapter 1), interest on the mortgage, real estate taxes, and other expenses attributable to the leased facility. The effect is to treat the facility as though it were owned by the provider. (See section 1212 of Chapter 12 regarding the treatment of the owner's equity in the leased assets.)

1011.6 Shared-Services Organizations

A group of providers may create a supplier organization by various means which generally include a pooling of provider resources. These "shared-services organizations," as they are typically called, are to be treated in the same manner as any other supplier. However, in determining if a relationship exists, the ownership or control interest must be viewed on an individual provider basis. For example, if an individual provider's interest, considering its individual ownership and/or control interest, in the shared-services organization is insignificant when compared to the interests of the entire group, then that provider is not related to the shared-services organization. This, of course, assumes that the providers are otherwise unrelated. For example, if all of the provider members of the shared-services organization are wholly owned subsidiaries of the same parent organization, that would create a relationship, even though any one individual provider's interest in the shared-services organization is insignificant.

1011.7 Special Purpose Organizations

A provider may establish a separate, special purpose organization to conduct certain of the provider's patient-care-related or nonpatient-care-related activities (e.g., a development foundation assumes the provider's fund raising activity). Often, the provider does not own the special purpose organization (e.g., a nonprofit, nonstock-issuing corporation), and has no common governing body membership. However, such a special purpose organization is considered to be related to a provider if:

a. The provider controls the special purpose organization through contracts or other legal documents that give the provider the authority to direct the special purpose organization's activities, management, and policies; or

b. The provider is, for all practical purposes, the sole beneficiary of a special purpose organization's activities. The provider should be considered the special purpose organization's sole beneficiary if one or more of the three following circumstances exist:

1. A special purpose organization has solicited funds in the name of and with the expressed or implied approval of the provider, and substantially all the funds solicited by the organization were intended by the contributor or were otherwise required to be transferred to the provider or used at its discretion or direction;

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COST TO RELATED ORGANIZATIONS

1011.7(Cont.)

2. The provider has transferred some of its resources to a special purpose organization, substantially all of whose resources are held for the benefit of the provider; or

3. The provider has assigned certain of its functions (such as the operation of a dormitory) to a special purpose organization that is operating primarily for the benefit of the provider.

Example: Provider T is a voluntary, nonprofit, acute care hospital governed by a 20-member board of directors. ABC Foundation, Inc., is a nonprofit development foundation engaged in various health care and nonhealth care related activities, some of which were performed by Provider T prior to the establishment of the foundation. ABC Foundation, Inc., is governed by a 12-member board of directors, none of which serve concurrently as directors of Provider T. The articles of incorporation, constitution, and bylaws of the foundation provide that the foundation's purpose is to perform fund raising, community relations, and provider outreach programs for the sole benefit of Provider T. The restrictive nature of the foundation's activities provides a sufficient connection for a finding of control between the entities. Thus, transactions between the provider and the development foundation will be as between related organizations.

4

## **PHPC mission**

The mission of the PHPC program is to improve access to health care for residents living in public housing communities, including family housing, elderly housing, Hope VI, Section 8 units and transitional housing. It is through providing primary health care, health promotion and disease prevention activities that the PHPC health centers improve the overall health, self-sufficiency and well-being of residents.

## **Public Housing Primary Care Health Centers**

The Public Housing Primary Care Program provides residents of public housing with increased access to comprehensive primary health care services through the direct provision of health promotion, disease prevention, and primary health care services. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents. In 2006, HRSA-funded health centers served over 129,000 residents of public housing.

## **Background**

The Public Housing Primary Care (PHPC) program was created under the Disadvantaged Minority Health Improvement Act of 1990 which amended the Public Health Service Act to include Section 340A. The program was reauthorized under Public Law 104-299, the Health Centers Consolidation Act of 1996 as Section 330(i) of the Public Health Service through the Health Care Safety Net Amendments and was reauthorized in 2002.

The PHPC program is funded through the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Currently HRSA funds 41 PHPC health centers located in 19 states throughout the nation. The PHPC program sites include urban, rural, mobile, on-site and clinical settings. These programs provide high-quality comprehensive health care services to 129,280 residents at approximately 155 service delivery sites.

PHPC programs are designed to provide residents of public housing, individuals and families who benefit from public rent subsidies, and other low-income persons living in areas accessible to public housing with increased access to comprehensive primary care and health-related services to improve their overall health and well-being and to eliminate health disparities. Services are provided on the premises of public housing developments or at other locations immediately accessible to residents.

The funding allows a PHPC grantee to establish a community health center within a public housing facility or near a public housing community. **This effort represents a close partnership between the community health center and the local public housing authority, in essence doubling the effort. PHPC health centers work in collaboration with public housing authorities to assess the needs of residents, meet with resident councils and conduct on-site outreach to the residents. Housing authorities also offer further assistance to PHPC programs through**

**participating in other funding opportunities that will support resident health programming and services.** Each PHPC project provides comprehensive primary health care services, which often include internal medicine, pediatrics, OB/GYN care, preventive and restorative dental care, health education, outreach, laboratory services and case management. Many PHPC health centers also provide behavioral health services, pharmacy, x-ray, optometry and podiatry, along with nutritional services through the Women, Infants and Children (WIC) program. By focusing on an integrated approach, PHPC health centers deliver high quality care to the target population. PHPC health centers serve as the hub of the community because they provide health education, primary care, support services, health promotion and prevention programs, and innovative initiatives to address chronic disease; in addition, they train and employ residents and provide a place for health-oriented events.

### **PHPC Partnerships and Collaborations**

PHPC health centers have an established history of creating strong partnerships with public, government, social, community-based, non-profit and educational institutions to augment primary care and social services provided to patients.

RHD partnered with Philadelphia Housing Authority and its tenant association in 1991 and that is why HRSA approved RHD as one of the seven section 330 (i) grantees in 1991.

Jul. 9. 2008 10:01AM FAMILY PRACTICE

No. 5386 P. 1

MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding is entered into by and between Abbottsford Homes Tenant Management Corporation (hereinafter AHTMC) a nonprofit Pennsylvania corporation with offices at 3210B McMichael Street, Philadelphia, PA 19129 and Resources for Human Development, Inc. (hereinafter RHD) a nonprofit Pennsylvania corporation with offices at 4101 Kelly Drive, Philadelphia, PA 19129, collectively referred to as the Parties on this 3rd day of May 1993.

WHEREAS, the parties desire to facilitate their charitable purposes by collaborating to provide health services to lower income persons including but not limited to persons residing at Abbottsford Homes public housing development (hereinafter site);

WHEREAS, RHD in partnership with AHTMC has received a grant for development and operation of a health care center from the U.S. Department of Health and Human Services (HHS) at the site for three years, subject to annual federal review and approval; and

WHEREAS, the parties desire to define their relationship, obligations and duties.

NOW THEREFORE, the parties in consideration of the mutual promises herein agree as follows:

PURPOSE, LOCATION, TERM

1. Purpose and Project. The Abbottsford Community Health Center (ACHC) is a joint project of AHTMC and RHD. ACHC is a resident driven, primary health care system emphasizing health promotion and disease prevention. The program focuses on promoting healthy life styles and will have two basic components:

a. on-site health care system supervised by a Certified Registered Nurse Practitioner with periodic consultation from a team of medical doctors; and

b. an outreach prevention/education system with a case worker serving as a case manager and outreach workers who will provide home visits, group education workshops, and advocacy.

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No. 5386 P. 2

1.1 Location. The ACHC shall be located at 3205 Defense Terrace, Philadelphia, PA 19129.

1.2 Term. The term of this agreement shall be from the date of execution until December 31, 1999, unless sooner terminated subject to fund availability.

### MANAGEMENT

2. Powers. The overall management and control of the business and affairs of ACHC shall be vested in a AHTMC/RHD management committee (Management Committee). Except where herein expressly provided to the contrary, all decisions with respect to management and control of ACHC that are "Approved by the Management Committee" shall be binding on ACHC and each party.

2.1 Composition. The Management Committee shall be composed of a total of seven (7) persons; four (4) appointed by AHTMC and three (3) persons appointed by RHD. Each person appointed by RHD is authorized to vote all three of RHD's votes.

2.2 Joint Development and Operations Obligations. No act shall be taken, sum expended, decision made or obligation incurred by ACHC or anyone acting on behalf of ACHC, the Management Committee, or either party with respect to a matter within the scope of any of the joint development and operations obligations listed below, unless and until the same has been approved by the Management Committee or expressly delegated by the Management Committee in writing. The joint development and operations obligations shall include:

a. the selection, termination or replacement of a contractor for construction of the Center;

b. the selection, termination or replacement of an architect for construction of the Center;

c. varying accounting methods and making other revisions with respect to treatment of various transactions for state or federal income tax purposes or other financial purposes from the present accounting system which complies with GAAP federal accounting and auditing standards, provided that such methods and decisions shall be consistent with the other provisions of this Agreement.

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- d. making any expenditure or incurring any obligation which when added to any other expenditure for the fiscal year of the ACHC exceeds the Budget or any category specified in the Budget by 15% of the annual budget.
- e. any action requiring HHS consent or approval;
- f. hiring and termination of the ACHC Program Director;
- g. the use, introduction, promotion or other utilization of experimental drugs, procedures or devices for health care treatment or diagnosis;
- h. review and approve personnel policies and performance evaluation criteria for Program Director.
- i. any other decision or action by any provision of this Agreement that is required to be Approved by the Management Committee or which materially affects ACHC or the assets or operations thereof.

2.3 Management Committee Meetings. The Management Committee shall meet at least quarterly and as needed.

#### ADVISORY COMMITTEE

3. Purpose. A maximum fifteen (15) person advisory committee shall provide advice to the parties in carrying out the activities of the ACHC.

3.1 Composition. The Advisory Committee will be appointed by the Management Committee and will include a majority of ACHC users.

3.2 Advisory Committee Obligations. The Advisory committee shall perform the following tasks for ACHC:

- a. The Advisory Committee is responsible to perform an annual evaluation of the work of the director. The Advisory Committee will submit this report to the Management committee.
- b. The Advisory Committee will prepare and deliver an annual report to the management committee.

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c. The Advisory Committee will provide advice and make recommendations when requested by the management committee, RHD or AHTMC on matters related to ACHC.

DEVELOPMENT AND OPERATIONAL OBLIGATIONS

4. RHD's Development and Operational Obligations. RHD agrees to perform the following tasks on behalf of ACHC:

a. RHD is responsible for the initial screening of candidates for the director of the ACHC and must present a minimum of two qualified candidates to the Advisory Committee for their review. The Advisory Committee will interview these candidates and will make a recommendation to the Management Committee, as to which candidate, (if any), should be hired for the director of ACHC.

b. RHD is responsible for reporting, compliance, and accounting to the U.S. Department of Health and Human Services.

c. RHD is responsible for payroll and general financial management and program evaluation of ACHC.

d. RHD is responsible for employee hiring and termination with the exception of the Program Director.

e. RHD shall provide monthly reports indicating the financial status of ACHC to the Management Committee and AHTMC.

4.1 AHTMC's Development and Operational Obligations. AHTMC agrees to perform the following tasks on behalf of ACHC:

a. AHTMC is responsible for the physical plant of ACHC;

b. AHTMC shall verify residency status and conduct reference checks for all AH residents who are being considered for employment by RHD related to ACHC.

Building Maintenance

5. Building Maintenance. AHTMC shall provide and RHD shall pay the cost of routine janitorial services, utilities and physical space at the location of ACHC as rent to AHTMC.

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No. 5386 P. 5

### Personnel

6. Personnel. The Program Director and other personnel of ACHC shall be employees, servants or agents of RHD and under its supervision and control, subject to the terms and conditions herein.

6.1 Benefits and Taxes. RHD shall be responsible for all employee benefits and taxes for employees and personnel employed by RHD.

### Compliance with HHS Grant

7. HHS Grant. RHD and the parties shall comply with the terms and conditions of the HHS Grant and as amended.

### Insurance

8. Liability Insurance. RHD is responsible for maintaining the following insurance in full force and effect for ACHC:

a. General liability and professional liability insurance for ACHC as required by Pennsylvania law with limits not less than \$1,000,000 per occurrence and \$3,000,000 aggregate.

b. Workmen's compensation insurance for ACHC personnel as required by Pennsylvania law.

8.1 Additional Insurance. RHD shall include AHTMC as an additional insured party with regard to the general comprehensive liability, fire and professional liability insurance.

8.2 Malpractice Insurance. RHD shall require all medical practitioners to maintain malpractice insurance as required by Pennsylvania law.

### Medical Decisions

9. Medical Decisions. AHTMC is not responsible for medical decisions made by or related to ACHC. AHTMC or Management Committee shall not make medical or treatment decisions for patients of ACHC.

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No. 5386 P. 6

Licenses

10. Licenses. RHD is responsible for requiring appropriate licenses or certifications by medical practitioners at ACHC.

Medical Research

11. Medical Research. Research as defined in 45 CFR Part 46 is prohibited by ACHC without the prior written consent of AHTMC and patient.

Inspection and Audit

12. Inspection and Audit. The U.S. Public Health Service and AHTMC may inspect or audit the financial records, books, accounts or other nonconfidential documents of ACHC or RHD related to ACHC.

Representations and Warranties

13. Representations and Warranties. AHTMC and RHD, covenant and agree that they will:

1. provide services under the grant without regard to the ability to pay;
2. ensure that if a charge is imposed, the charge will (a) be made according to a schedule of charges that is made available to the public, (b) not be imposed on residents with income below the poverty level; and (c) be adjusted to reflect the income and resources of the residents of public housing involved.

Negative Covenants

14. Negative Covenants. AHTMC and RHD, covenant and agree that they will not, either directly or through contract, expend grant funds:

1. for any purpose other than the purposes authorized by Section 340A of the Public Health Service Act;
2. to provide inpatient services;
3. to make cash payments to intended recipients of health care services;

Ex H 8

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No. 5386 P. 7

Equal Employment Opportunity15. Equal Opportunity.

a. The ACHC will not discriminate against any employee or applicant for employment because of race, color, religion, sex, handicap or national origin. The ACHC will take affirmative action to insure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, handicap or national origin. Such action shall include, but not be limited to, the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The ACHC agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Local Public Agency setting forth the provisions of this nondiscrimination clause.

b. The ACHC will, in all solicitations or advertisements for employment placed by or on behalf of the ACHC, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, handicap, or national origin.

c. The ACHC will cause the foregoing provisions to be inserted in all subcontracts for any work covered by this Contract so that such provision will be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

Resident Employment

16. Resident Employment. ACHC and RHD shall employ residents of Abbottsford Homes to the maximum extent feasible and in accordance with any collective bargaining agreements between the Philadelphia Housing Authority and past and present unions related to AHTMC's management of Abbottsford Homes.

Termination

17. Termination. This agreement may be terminated upon the mutual consent of the parties or for cause. If a party requests termination for cause, the offending party shall receive a reasonable time or thirty (30) days to cure the cause.

Jul. 9. 2008 10:03AM FAMILY PRACTICE

No. 5386 P. 8

Dispute Resolution

18. Dispute Resolution. The parties will endeavor to resolve disputes in a reasonable and timely manner.

Notices

19. Notices. Notices shall be provided in writing to each party as identified below:

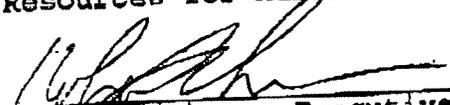
Executive Director  
Resources for Human Development  
4101 Kelly Drive  
Philadelphia, PA 19129

President  
AHTMC  
3210B McMichael Street  
Philadelphia, PA 19129

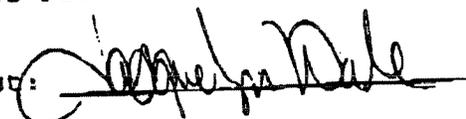
Program Director  
3205 Defense Terrace  
Philadelphia, PA 19129

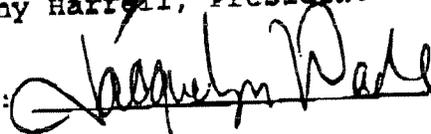
Resources for Human Development

Abbottsford Homes Tenant  
Management Corporation

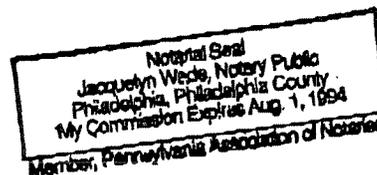
  
Robert Fishman, Executive Dir.

 6-2-92  
Dorothy Harrell, President

Attest: 

Attest: 

wp51-AH\*3  
MOU-RHD.AH



Ex 8

# INVOICE

	Rent	utilities	Janitorial	Total
January, 1995	\$1,600	\$ 500	\$1,376	\$3,476
February, 1995	\$1,600	\$ 500	\$1,376	\$3,476
March, 1995	\$1,600	\$ 500	\$1,376	\$3,476
Total 1st quarter	\$4,800	\$1,500	\$4,128	\$10,428
April, 1995	\$2,133	\$ 666.50	\$1,376(1)	\$4,175
May, 1995	\$2,133	\$ 666.50	\$1,376(1)	\$4,175
<b>TOTAL DUE</b>	<b>\$9,066</b>	<b>\$2,832</b>	<b>\$6,880</b>	<b>\$18,778</b>

(1) Janitorial cost to increase to \$1,770/month upon completion of additional unit.

Effective, April 1, 1995 an additional cost of \$533 is added to rent for the lost of this rental unit to AHIMC. An additional cost for utilities (\$166) will begin April 1, 1995 to cover utility cost during the construction phase. An additional projected cost of

All payment will be due the first of each month in advance.

Exhibit 9



[Home](#)
[About PHA](#)
[Housing](#)
[Resident Services](#)
[Doing Business with PHA](#)
[Jobs](#)
[Pressroom](#)
[Contact Us](#)
[Links](#)

[Tenant Support](#)
[Career Training](#)
[Youth Programs](#)
[Senior Programs](#)
[Homeownership](#)
[Life Skills](#)
[Health Clinics](#)
[Counseling](#)

Home » Resident Services » Tenant Support

About TSSI

The PHA  
Experience

TSSI Resident  
Councils

TSSI Self  
Sufficiency

Resident Advisory  
Board

## About TSSI

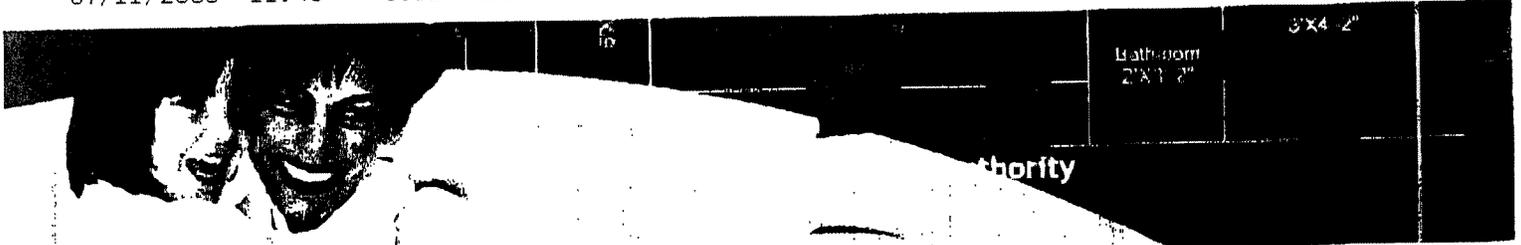
Tenant Support Services, Inc. (TSSI), is a charitable organization (501(c)(3)) led by a resident of public housing. TSSI works with PHA to prioritize resident issues. It ensures that residents' needs are met.



Some of the programs and services offered to PHA residents include:

- Family Self Sufficiency Center North
- Pre Apprenticeship Program In the Building and Construction Trades
- Certified Nursing Assistant, Medical Billing, and Pharmacy Technician Training Programs
- Homeownership Program
- Resident Owned Business Development Assistance
- Skills for Life Youth Program
- Summer Food Service Program
- Site Based Computer Labs
- Site Based Health Clinics
- Early Childhood Education Program - Head Start and Day Care
- Senior Centers and Satellite Centers - Meals and Activities
- Senior Transportation
- Clean Sweep/ Sparkle Plus

Tenant Support Services, Inc.  
Asia Coney, Director  
642 N. Broad Street, Lobby Level  
Philadelphia, PA 19130  
Phone: (215) 684-1016  
Fax: (215) 684-1017



Bathroom  
2'x3'2"

3'x4'2"

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### On-Site Health Clinics



The Philadelphia Housing Authority strives to provide its residents with access to quality health care. In conjunction with LaSalle University, MCP-Hahneman and Temple University, PHA residents have easy access to health care at Richard Allen, Hill Creek, and Abbottsford Homes.

- (215) 843-9720 (Abbottsford Homes) *RHD*
- (215) 728-6404 (Hill Creek) *PHMC*
- (215) 769-1100 (Richard Allen Homes) *DREXEL-RHD*

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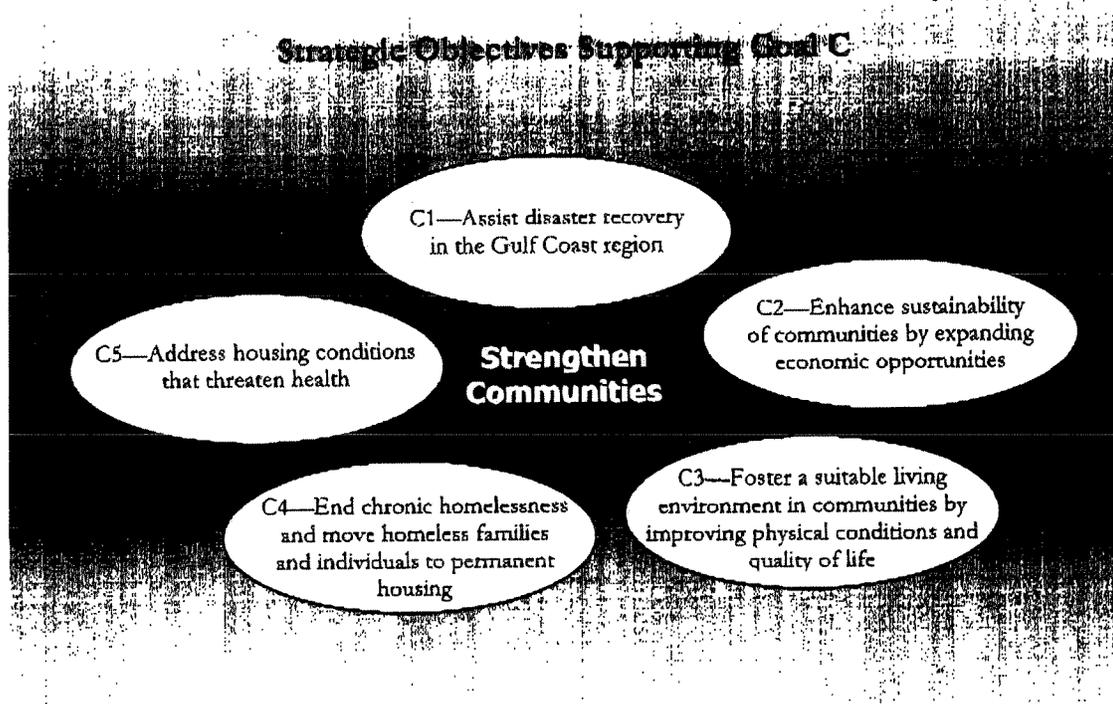
    Key Statutes 76

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# Strategic Goal C: Strengthen Communities

*"HUD continues to improve the way we do business with those providing housing and services to the people and places that need it most."*

*—Secretary Alphonso Jackson*



## Overview

The federal community development programs administered by HUD target their benefits to low- and moderate-income people and have been successful in stabilizing and revitalizing communities across the nation. Through the programs of HUD's Office of Community Planning and Development (CPD), HUD supports the development efforts of states, local communities, and other HUD partners.

A key component of this goal is the Community Development Block Grant program that has built and rehabilitated homes, fueled business development to create jobs, and improved the overall health of our nation's communities. The

Bush Administration proposes to reform the CDBG program to more effectively contribute to local community and economic progress. Formula changes will be proposed to direct more of the program's base funding to communities that cannot meet their own needs and bonus funds will be available to communities that demonstrate the greatest progress in expanding homeownership and opportunity for their residents.

Additionally, the HOME program helps strengthen communities by expanding the availability of homeownership and affordable rental housing. CPD also administers HUD's

Ex 4 12

*HUD's Strategic Goals*

homeless programs, which are an essential part of the Administration's strategy for eliminating chronic homelessness.

A new focus for this strategic goal is to strengthen the effectiveness of federal efforts to provide economic and community development opportunities to low-income households. HUD is working with grantees, interested parties, and other federal agencies to develop and implement performance measures and outcomes for these programs.

Other HUD offices contribute to this goal through maintaining and promoting quality affordable housing in neighborhoods, reaching out to communities through University Partnerships, making affordable capital available to construct and modernize hospitals, and fostering international exchanges on housing, community development, and urban planning.

This strategic goal has five objectives:

***Objective C1: Assist disaster recovery in the Gulf Coast region.***

During 2005, Hurricanes Katrina, Rita, and Wilma ravaged Louisiana, Mississippi, Alabama, Florida, and Texas and displaced hundreds of thousands of people. The people and infrastructure of the city of New Orleans were hit particularly hard. HUD is working with the Federal Emergency Management Agency to meet the emergency housing needs. The Department also has estimated that over 125,000 housing units were severely damaged or destroyed by Hurricanes Katrina, Rita, and Wilma, and another 179,000 units received major damage. As Congress looked toward long-term reconstruction strategies, it provided \$11.5 billion through the CDBG program in December 2005. The Department has requested that Congress provide additional supplemental funding of \$4.2 billion for community development and continued rental assistance for Louisiana. Under this objective, HUD will use supplemental appropriations to support the recovery of housing and critical infrastructure in the Gulf region so the citizens can rebuild their communities and lives.

***Objective C2: Enhance sustainability of communities by expanding economic opportunities.***

Communities cannot be viable places to live without economic resources. A key objective of HUD's community and economic development

programs is to help improve economic conditions in distressed communities. Economic development is a key activity under the CDBG program. Funded activities include job creation and retention, as well as education, training, and services that strengthen the workforce. Grantees may also use CDBG funds to invest in infrastructure and housing improvements, which can spur further economic growth. HUD, in consultation with grantees and other interested parties, has developed a performance measurement framework for the formula grant programs (CDBG, HOME, HOPWA, and Emergency Shelter Grants) that will focus on three objectives, one of which is creating economic opportunities. Through this framework, HUD will be able to measure the extent to which the formula programs are supporting this strategic objective.

HUD funds promote economic development even when that is not the primary purpose. Section 3 of the Housing and Urban Development Act of 1968 requires that when HUD provides financial assistance to grantees in economically distressed areas, the resulting jobs, training, and contracts will be given to low- and very-low-income persons in those areas to the greatest extent feasible.

***Objective C3: Foster a suitable living environment in communities by improving physical conditions and quality of life.***

Decent public services and amenities, safe, clean streets, adequate infrastructure, and homes free from environmental hazards are among the many factors that influence quality of life for members of a community. A range of HUD programs target funds to address such quality-of-life issues in low-income communities and households.

For example, local communities often use CDBG funds for roads, sewers, and other infrastructure investments, or for community centers, parks, and other assets that help to strengthen and revitalize their low-income neighborhoods. HUD also funds housing development and rehabilitation through CDBG, HOME, Youthbuild, and Lead Hazard Control grants, and provides FHA mortgage insurance to make private capital more available for homeownership, affordable rental housing, and healthcare facilities.

*Strengthen Communities***Objective C4: End chronic homelessness and move homeless families and individuals to permanent housing.**

HUD is committed through its Continuum of Care to ending chronic homelessness. HUD's working definition of a person experiencing chronic homelessness is an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has had recurring episodes of homelessness. Estimates of the number of persons experiencing chronic homelessness range from 150,000 to 200,000. Even when housing is available, disabilities sometimes make it difficult for chronically homeless persons to remain in that housing for long periods unless they also have supportive services, including case management and regular healthcare.

While those experiencing chronic homelessness are often the most visible of the homeless population, there is also a substantial number of families and individuals who experience a more temporary crisis, such as loss of employment or eviction, and become homeless. HUD's approach to replacing homelessness with housing stability relies on three coordinated efforts:

- Preventing homelessness;
- Developing permanent and transitional housing for both those persons experiencing chronic homelessness and the growing numbers of homeless families;
- Coordinating housing assistance with supportive services.

Given the variety of individual needs and locally available resources, communities are in the best position to design strategies to help each homeless person and family achieve permanent housing and self-sufficiency. HUD's homeless assistance programs will continue to foster local initiatives by providing flexibility while providing incentives to meet important national objectives, including ending chronic homelessness.

HUD allocates the federal government's largest amount of targeted homeless assistance under the McKinney-Vento Homeless Assistance Act through its annual Continuum of Care (CoC) competition and by formula through the Emergency Shelter Grants program. Communities also address homeless needs through the use of CDBG, HOME, and HOPWA programs and through the use of HUD's other

mainstream housing programs, such as Housing Choice Vouchers and the public housing program.

**Objective C5: Address housing conditions that threaten health.**

A safe housing stock is a critical precondition for safe, livable communities. Along with its responsibility for HUD-assisted private housing and public housing, HUD addresses hazards in unassisted private housing. The Department regulates the construction and inspection of manufactured housing. HUD also remains committed to reducing mold and other residential health and safety hazards through a comprehensive, cost-effective Healthy Homes approach, and to eliminating the poisoning of children by lead-based paint in older homes. The Department makes housing, especially for low-income families, safe from these residential environmental hazards through grants; in the case of lead hazards, HUD also does so by regulating the sale or lease of older housing, and by regulating assistance to older housing. HUD's research improves methods for detecting, assessing, and controlling these residential environmental hazards. HUD supports research and development of housing construction that resists natural disasters, such as hurricanes, floods, earthquakes, tornados, and firestorms.

In addition, for persons with HIV and other chronic health challenges, the risks of homelessness pose a direct threat to their health, stability, and relative wellness. The Department's homeless assistance programs and the HOPWA program are vital tools in reducing the health consequences for persons who are homeless or at severe risk of homelessness.

**Means and Strategies*****Support community and economic development.***

HUD funds a variety of programs that support the community and economic development efforts of state and local communities. HUD's strategy focuses on providing and coordinating resources for neighborhood revitalization and other community development efforts by local partners. By employing these resources for building local economies and developing community assets, communities can leverage local contributions to address their priority problems:

## Interagency Partnerships

HUD relies extensively on partnerships to accomplish its mission. While such partnerships may not be commonly recognized as resources supporting HUD's mission, they are in fact resources, and many of HUD's goals could not be met without the active participation of partners.

HUD's partners include numerous organizations in the private sector, including both for-profit and nonprofit organizations, as well as state and local governments. Other federal agencies also are critical to HUD's success, while HUD likewise supports the missions of other agencies. The interagency cooperation that is planned during the period covered by this Strategic Plan is summarized for each strategic goal below.

### ***Strategic Goal A: Increase homeownership opportunities***

- Ginnie Mae will continue to guarantee mortgage-backed securities backed by pools of mortgages that are insured by the FHA and the Department of Agriculture's Rural Housing Service (RHS) or guaranteed by the Department of Veterans Affairs (VA).
- To implement and enforce the Real Estate Settlement Procedures Act (RESPA) effectively, HUD will enhance coordination with the major banking regulators including the Federal Deposit Insurance Corporation (FDIC), the Comptroller of the Currency, the Office of Thrift Supervision, and the Federal Reserve Board. In addition, HUD will work with the Department of Justice, the Federal Trade Commission, and state attorneys general, and regulators on joint enforcement actions.
- HUD also will continue to work cooperatively with the above regulatory agencies to collect data under the Home Mortgage Disclosure Act (HMDA). The Federal Financial Institutions Examination Council is the governing board that is responsible for collecting and disseminating this information. HMDA data show how mortgage credit is provided across the country and are invaluable in assessing disparities in lending practices among mortgage lenders that affect underserved groups.

- HUD will continue to work with agencies, such as the Department of the Treasury to address predatory lending. The Interagency Task Force on Predatory Lending consists of federal law enforcement and banking supervisory agencies jointly seeking solutions to the problem of predatory lending. In 2005, the Office of Federal Housing Enterprise Oversight required GSEs to begin reporting cases of mortgage fraud. These data will greatly enhance understanding of the scope and nature of mortgage fraud.
- HUD cooperates with the Department of Justice to enforce fair housing laws that prohibit discrimination on the basis of minority status or disability. HUD also serves on the Interagency Task Force on Fair Lending, whose members include the Departments of Justice and the Treasury, FDIC, Federal Housing Finance Board, Federal Reserve Board, Federal Trade Commission, National Credit Union Administration, Office of Federal Housing Enterprise Oversight, Office of the Comptroller of the Currency, and Office of Thrift Supervision. The Task Force coordinates fair lending activities across all federal agencies.
- Under a plan approved by the Federal Housing Finance Board, HUD formed a new partnership with the Federal Home Loan Bank (FHLB) of Seattle to buy up to \$100 million in loans guaranteed by HUD under Title VI of the Native American Housing Assistance and Self Determination Act. HUD guarantees of principal and interest will help create an incentive for other financial institutions to extend financing to Native American communities.

### ***Strategic Goal B: Promote decent affordable housing***

- HUD has a cooperative agreement with the Department of Health and Human Services (HHS) to implement the National Directory of New Hires (NDNH) database. This allows HUD to conduct quarterly data matching of HHS employment information with HUD public housing and Housing Choice Voucher

*Interagency Partnerships*

(HCV) program participants nationally. The data matching is projected to minimize the \$1.2 billion in improper payments stemming from tenant underreporting of income. Access to the NDNH database provides public housing agencies that administer HUD programs in local communities the information they need to validate tenant-reported income of individuals participating in HUD's public housing and HCV programs.

- In 2005 and 2006, the Federal Emergency Management Agency (FEMA) contracted with HUD to operate the Katrina Disaster Housing Assistance Program (KDHAP). Under the program, HUD-assisted renters and homeless individuals displaced by the Gulf Coast hurricanes can receive housing assistance for up to 18 months. In 2006, HUD continued to operate the program under 2006 supplemental funding.
- HUD will continue to work with the Department of the Treasury to ensure efficient use of the Low-Income Housing Tax Credit (LIHTC). HUD has done significant research on the tax credit program to inform LIHTC policy. HUD sets the maximum LIHTC rents by publishing estimates of 60 percent of area median income, and identifies Difficult Development Areas and Qualified Census Tracts – areas where tax credits can be taken on a higher percentage of a project's "qualified basis." HUD's Office of Housing continues to work with Treasury to make the LIHTC program work better with FHA insurance. HUD also works closely with Treasury on tax-exempt bond regulations and other tax policy rulings that affect the continued provision of quality multifamily housing with affordable rents.
- HUD recently signed a memorandum of understanding (MOU) with the USDA Rural Housing Service. The purpose of this MOU is to ensure an ongoing working relationship between HUD and the RHS in preserving affordable rental housing in rural America. The MOU will facilitate the processing of Multifamily Housing Assistance Payment contract renewals for RHS-financed projects.
- \* HUD is continuing a pilot program in 11 states called Project Access, a joint effort between HUD and HHS, designed to ease the transition of nonelderly persons with disabilities from nursing homes into community living.
- HUD will work with the Environmental Protection Agency (EPA) and the Department of Energy in a partnership that supports the goals of the President's National Energy Policy and the Energy Policy Act of 2005 by promoting more widespread construction to meet Energy Star qualifications and use of Energy Star products in HUD's inventory of public, assisted, and insured housing, and by CDBG and HOME grantees.
- HUD and the Federal Housing Finance Board signed a MOU in 1999 that sets forth the policy for approving the use of FHLB Affordable Housing Program (AHP) funds for subordinate financing of Section 202 and Section 811 projects. The need for a policy was prompted because sponsors of these properties were increasingly approaching FHLBs for AHP subordinate financing, for a variety of reasons. The MOU streamlined the approval process and decreased the time it takes for financing to become available for these projects, which house elderly and disabled persons.
- HUD will continue to work closely with a number of federal agencies, including the Departments of Health and Human Services and Labor, to ensure the successful implementation of welfare reform policies designed to help low-income families make progress toward self-sufficiency. HUD serves on the Interagency Committee on Supports for Low-Income Workers, promotes the HHS Assets for Independence competitive grant program through HUD's communications mechanisms, and assists HHS in its technical assistance program for state welfare agencies, including through technical assistance conferences and broadcasts. HUD also encourages HUD-funded employment and training programs, as well as subsidized housing providers to: (1) establish and maintain Neighborhood Networks Centers for the implementation of such programs, and (2) coordinate and partner with the Department of Labor's national system of One-Stop Employment Centers.
- HUD has worked with HHS to develop guidance and a model cooperative agreement for PHAs and local welfare agencies. PHAs are encouraged to enter into cooperative agreements with local welfare agencies to target services and assistance to welfare .

*Aligning Resources with Results*

families who receive housing assistance, as well as to reduce fraud and noncompliance with program requirements.

- \* • HUD and HHS work collaboratively to increase the availability of assisted living facilities for low-income seniors, especially through coordination with states that have Medicaid waivers and can spend Medicaid funds on assisted living services.
- HUD signed a MOU with the FDIC to establish a national partnership to promote financial education using Money Smart, FDIC's financial education curriculum. FDIC and HUD continue to educate over 4,000 PHAs to support Welfare to Work vouchers.
- HUD works with the Department of Education to inform residents through Neighborhood Networks Centers of the financial aid opportunities available to them to further their education.
- HUD works with the National Aeronautics and Space Administration (NASA) through Neighborhood Networks Centers to provide opportunities for residents of FHA-insured and assisted multifamily housing properties to be exposed to career possibilities in the areas of science and math.

**Strategic Goal C: Strengthen communities**

- HUD is a member of the U.S. Interagency Council on the Homeless. The other federal departments represented on the Council include the Departments of Agriculture, Commerce, Defense, Education, Energy, HHS, Justice, Labor, Interior, Transportation, and VA, the Social Security Administration, the Federal Emergency Management Agency, the General Services Administration, the Office of Management and Budget, the National Corporation for National Community Services, and the U.S. Postal Service. The Council coordinates federal programs supporting homeless families and individuals to minimize duplication and improve overall results.
- Through a MOU with the Internal Revenue Service (IRS), HUD is helping link low-income individuals and families to free tax preparation, electronic filing, and asset building assistance. The partnership promotes a national tax assistance program

using the IRS Volunteer Income Tax Assistance program.

- HUD will continue to work with the Departments of HHS and VA to better integrate HUD housing for homeless persons with HHS and VA service resources. The three agencies will continue to sponsor policy academies with state agencies to bring senior state and local policymakers together to discuss how to improve access to mainstream federal service programs by persons who are homeless.
- HUD is collaborating with HHS and the White House Office of National AIDS Policy in assisting our community partners in addressing the challenges from the HIV epidemic. These efforts involve the coordination of training and technical assistance for providers of housing, healthcare, and other social services for persons with HIV/AIDS, including participation by grassroots and faith-based community organizations. In addition, HUD is collaborating with the Centers for Disease Control and Prevention (CDC) on a study of the connections of homelessness or stable housing to HIV transmission and the progression of HIV disease, to assist CDC in gaining understanding in addressing the special needs associated with HIV and in helping prevent HIV transmission.
- HUD works with the Department of Justice and the EPA to enforce the Lead Disclosure Rule of the Residential Lead-Based Paint Hazard Reduction Act of 1992, which requires that landlords and sellers of housing constructed prior to 1978 provide each purchaser or tenant with information about lead hazards.
- HUD is working on the Healthy Homes Initiative with the CDC, the EPA, the National Institute for Occupational Safety and Health, the National Institute of Standards and Technology, and the National Institute of Environmental Health Sciences. Under the initiative, HUD awards grants to public and private organizations and makes agreements with other federal agencies for evaluation studies and demonstration projects to address housing conditions responsible for diseases and injuries.

*Interagency Partnerships*

- HUD is continuing joint research with FEMA that will help reduce the risk and economic impacts of floods.
  - As part of HUD's commitment to the environment, the Department works with the Council on Environmental Quality to enhance environmental compliance and with the Department of Energy to foster energy savings and innovation. HUD also is a member of the Advisory Council on Historic Preservation and actively supports the integration of historic preservation in the administration of its programs.
  - In a partnership that has lasted 37 years, HHS assists HUD in administering its program of mortgage insurance for hospitals. HHS provides architectural and engineering services, helps HUD evaluate applications, and supports HUD's monitoring of the hospitals in the portfolio. The departments recently signed a new Interagency Agreement that extends this partnership for another five years.
- HUD and the Department of Justice continue to coordinate their fair housing enforcement activities, especially with respect to responding quickly and effectively to Fair Housing Act complaints that involve criminal activity (e.g., hate crimes), a pattern and practice of housing discrimination, or the legality of state and local zoning or other land use laws or ordinances.
  - HUD will continue to work with the Departments of Justice and Treasury to ensure that LIHTC projects are in compliance with the Fair Housing Act. Under a MOU, the three agencies formalized a monitoring and compliance process to ensure that low-income housing tax credit properties meet the requirements of the Fair Housing Act.
  - HUD is partnering with HHS to help states and communities comply with *Olmstead v. L.C.* by providing community living options for persons with disabilities. In the pilot initiative, HUD is supplying vouchers and technical assistance, while HHS, working through state Medicaid agencies, is providing Nursing Home Transition Grants, Medicaid funds, and other resources to facilitate the transition to community living.

***Strategic Goal D: Ensure equal opportunity in housing***

- HUD chairs the President's Council on Fair Housing, which is an interagency group committed to promoting equal opportunity in mortgage lending, and serves on the Interagency Task Force on Fair Lending, which coordinates enforcement of fair lending laws across the federal government. Through the Interagency Task Force on Fair Lending, HUD works with the Departments of Justice and the Treasury, the FDIC, Federal Housing Finance Board, Federal Reserve Board, Federal Trade Commission, National Credit Union Administration, Office of Federal Housing Enterprise Oversight, Office of the Comptroller of the Currency, and Office of Thrift Supervision to provide guidance to lenders consistent with the Fair Housing Act and the Equal Credit Opportunity Act and their implementing regulations.
  - The Interagency Working Group on Limited English Proficiency (LEP), chaired by the Office of the Assistant Attorney General Civil Rights Division of the Department of Justice, consists of representatives from all federal civil rights offices. The group is working to ensure effective and efficient implementation of Executive Order 13166 and Title VI of the Civil Rights Act of 1964 as it relates to LEP
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***Strategic Goal E: Embrace high standards of ethics, management, and accountability***

- HUD will continue to rely on the Department of Justice to accept civil referrals of multifamily development owners who have troubled management. Criminal referrals are sent to HUD's Inspector General.
- HUD will continue to show leadership in housing and community development policy by supporting cooperative research efforts. These include the National Survey of

*Aligning Resources with Results*

Homeless Assistance Providers and Clients (involving HHS, along with a number of other agencies); an Interagency Agreement with the Department of Justice's National Institute of Justice to evaluate drug elimination strategies; and coordination with the Department of State to enter into MOUs to facilitate information exchange with counterpart housing officials from other countries.

- HUD continues to participate in the interagency FedStats task force to facilitate electronic data dissemination. FedStats is intended to provide an interagency clearinghouse for statistical data that will transform existing information searches from a fragmented, agency-focused process to a more unified and customer-oriented one.

***Strategic Goal F: Promote participation of faith-based and community organizations***

- HUD's CFBCI will partner with the Centers for Faith-Based and Community Initiatives at the Departments of Education, HHS, Justice, and Labor to plan and conduct interagency events and conferences. The conferences are designed to educate and train faith-based and community organizations on partnership opportunities, launch pilot and demonstration projects, and build partnerships between corporations, foundations, and nonprofit organizations. The Corporation for National Community Service will also play a role, and the Department of Agriculture will also be invited to participate. The effort will strengthen the capacity of faith-based and other community organizations to better meet the social and economic needs in America's communities.





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## Welcome

### What is The Philadelphia Housing Authority?

"At PHA, we're bringing more than hope to this great city. We're bringing homes."

- Carl R. Greene, Executive Director, PHA

The Philadelphia Housing Authority, also known as PHA, is the biggest landlord in Pennsylvania.

We develop, acquire, lease and operate affordable housing for city residents with limited incomes.

Our funding comes primarily from the federal government. We also work in partnership with the city and state governments as well as private investors.

Although we are a public agency, we operate in many ways like a private property management company. We employ the best practices of the private real estate industry.

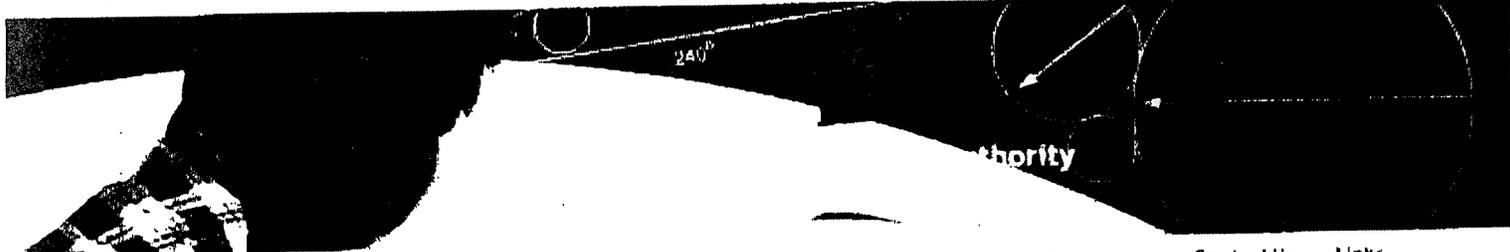
PHA was established in 1937 and is the nation's fourth largest housing authority. We house about 84,000 people in the City of Philadelphia and we employ 1,150 people to deliver services to our clients. Our budget totals \$347 million.

It's our policy to serve our customers without regard to race, color, religion, national origin, ancestry, age, sex, sexual orientation, having AIDS, physical handicap, or disability.

It's our policy to serve our customers without regard to race, color, religion, national origin, ancestry, age, sex, sexual orientation, having AIDS, physical handicap, or disability.

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Client Services/Housing Choice

### Program Compliance/HOPE VI CSS

Conventional Sites Maintenance

Program Compliance/HOPE VI CSS Department promotes economic development and supportive services for PHA residents. We do this by matching PHA's funds with money from other public agencies and private investors.

Development

Design

Program Compliance - Hope VI  
Rylanda Wilson, Supervisor  
3226 McMichael Street  
Philadelphia, PA 19129

Finance

Human Resources

Information

Systems Management

*VIRGINUS BRAGGS*

Major Systems

Maintenance Division

*215-684-4295*

Materials

Office of Inspector

General Philadelphia Housing Authority

Office of Strategic Management (OSM)

PAPMC

PHA Police

Program Compliance/HOPE VI CSS

Scattered Sites Management

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## Philadelphia Housing Authority

[Record group 152]

### Agency home page. Agency Function

The Authority's main function is the clearance of slum areas and the construction in them of low-rental housing, made available to families below certain income levels. These projects are financed through federal and private funds which are repaid through bonds issued by the Authority.

### Agency History

The Philadelphia Housing Authority was created as a corporate body under the provisions of an Act of Assembly of 28 May 1937 and administered by a five-member board, of whom two are appointed by the Mayor and two by the City Controller; these in turn appoint the fifth member. The Authority is independent of the city government. It is a nonprofit, quasi-public corporation, chartered to provide safe, sanitary, decent housing for families of low income. The federally aided program of the Housing Authority was authorized under federal Housing Acts of 1937 and 1940 and by a "cooperation agreement" of 1950 with the City of Philadelphia and the Philadelphia Board of Education.

### Archival Records

152.1 Annual and Biennial Reports (1937-1941, 1950-1955, 1960-1961, 1963-1964, 1974, 1976, 1991)

152.2 Real Estate Property Survey. General Survey Tables (1939)

152.3 Queen Lane Housing Project. Drawings (1953)

152.4 Wilson Park Housing Project. Drawings. (1952)

152.5 By-Laws (1939, amended to 1969.)

152.6 Personnel Division. Annual Report (1 May 1951-15 June 1952)

152.7 Reports and Publications (1949-1957)

### Current Records

*Unavailable*

*Website*

<http://www.phila.gov/phils/Docs/Inventor/Graphics/agencies/A152.htm>

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Building Beyond Expectations

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### PHA Fast Facts



- 4th largest housing authority in the nation
- Pennsylvania's largest landlord
- Established in 1937
- Executive Director Carl R. Greene (March 9, 1998)
- Total budget of \$312 million
- Serves 84,000 people with affordable housing
- Employs 1,225 people
- Has over 50 developments
- Has more than 4,000 occupied scattered housing units (scattered sites)
- Manages the Housing Choice Voucher Program, with more than 16,000 households
- Supervised by a five-member Board of Commissioners:
  - two appointed by the Mayor
  - two appointed by the City Controller
  - one appointed by the other four members of the Board

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- [BUILDER Online: Everything You Need to Know About Home Building](#)
- [CCD Housing Task Force](#)
- [Center for Urban Community Services, Inc.](#)
- [Citizen's Housing and Planning Association](#)
- [City of Philadelphia Official Site](#)
- [Community Associations Institute](#)
- [Community Development Housing Foundation](#)
- [Co-op Housing Coalition](#)
- [Council of Large Public Housing Authorities](#)
- [Fair Housing Legal Support Center](#)
- [FannieMae](#)
- [HMDA Standard Reports -- RTK NET](#)
- [Habitat for Humanity](#)
- [Home Path - FannieMae Mortgages](#)
- [Housing America](#)
- [Housing Assistance Council \(HAC\)](#)
- [Housing Information Gateway](#)
- [Housing Research Foundation](#)
- [HUD Approved Housing Counseling Agencies](#)
- [Innovative Housing Institute Home Page](#)
- [Joint Center for Housing Studies Home Page](#)
- [Low-Income Home Energy Assistance Program \(LIHEAP\) Clearinghouse](#)
- [Low Income Housing Tax Credit Directory](#)
- [National Affordable Housing Management Association](#)
- [National Affordable Housing Network](#)
- [National Association of Housing Cooperatives](#)
- [National Association of Housing and Redevelopment Officials](#)
- [National Community Reinvestment Coalition](#)
- [National Fair Housing](#)
- [National Housing Conference](#)
- [National Housing Institute/Shelterforce Magazine](#)
- [National Housing & Rehabilitation Association](#)
- [National Housing Trust](#)
- [National Low Income Housing Coalition](#)

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- National Multi Housing Council
- Pennsylvania Housing Finance Agency
- Pennsylvania Protection & Advocacy, Inc.
- Public Housing Authorities Directors Association
- Real Estate: Renting, Buying and Neighbors
- State of Pennsylvania Official Government Site
- Tenant Net Home Page
- U.S. Department of Housing and Urban Development (HUD)
- U.S. Federal Government Official Site

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*Neighborhood Networks*



*Neighborhood  
Networks*

*Linking Residents  
to Healthcare  
Resources*

U.S. Department of Housing and Urban Development  
Office of Multifamily Housing Programs  
[www.NeighborhoodNetworks.org](http://www.NeighborhoodNetworks.org)  
(888) 312-2743

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## **Neighborhood Networks Information**

For more information about Neighborhood Networks, visit the Neighborhood Networks Web site at [www.NeighborhoodNetworks.org](http://www.NeighborhoodNetworks.org) or contact the Neighborhood Networks Information Center toll-free at (888) 312-2743, or TTY at (800) 483-2209. The Web site contains valuable information for centers, including:

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Neighborhood Networks Coordinators listing.

### **Center Database**

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### **Property Database**

Information about Neighborhood Networks properties listed geographically by state.

### **Resources Database**

Information about funding, technical assistance, publications, and Web site resources.

### **News Database**

Articles, press releases, success stories, and grand openings relevant to Neighborhood Networks.

### **List of Conferences**

Calendar of conferences and training events.

### **List of Resident Associations**

List of Neighborhood Networks properties with active resident associations.

### **Neighborhood Networks Consortia**

List of Neighborhood Networks consortia.

### **Senior Properties**

List of senior properties with operational Neighborhood Networks centers.

### **Online Networking**

Talk with Neighborhood Networks staff and stakeholders via online networking.

### **Publications**

- **Fact sheets.** Fact sheets are one-page summaries of various topics relevant to the operations of Neighborhood Networks centers. Fact sheets that are currently available include an overview of the Initiative, health information, childcare, transportation, seniors, and community improvements at Neighborhood Networks centers.
- **Network News** (current and past issues). A semiannual newsletter that highlights national achievements for a wide audience, including partners and the public.
- **NNewsline** (current and past issues). A semiannual newsletter that highlights topics of interest to Neighborhood Networks centers and Coordinators.

# Linking Residents to Healthcare Resources

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The guides in this series offer information on starting a center, creating programs and identifying center partners, marketing and media outreach, sustainability, funding, and much more. These updated guides feature new contacts, resources, case studies, and helpful information.

Neighborhood Networks is a community-based Initiative established by HUD in 1995 that continues to strengthen and grow throughout the United States, Puerto Rico, and the U.S. Virgin Islands. These community learning centers provide residents of HUD insured and assisted properties with programs, activities, and training that promote economic self-sufficiency.

This guide was published in 2005.

To receive copies of this publication or any others in the series, contact:

U.S. Department of Housing and Urban Development  
Neighborhood Networks  
2277 Research Boulevard, 5J  
Rockville, MD 20850

Neighborhood Networks Information Center  
Toll-free: (888) 312-2743  
E-mail: [neighborhoodnetworks@hud.gov](mailto:neighborhoodnetworks@hud.gov)  
TTY: (800) 483-2209

All publications are available from the Neighborhood Networks Web site at [www.NeighborhoodNetworks.org](http://www.NeighborhoodNetworks.org).

Copies of this TA guide are available in Spanish and can be requested from the Neighborhood Networks toll-free Information Center at (888) 312-2743.

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EXH 15

## ***Linking Residents to Healthcare Resources***

Many low-income individuals and families lack access to preventive and primary healthcare, often relying on emergency room visits in a crisis. Yet families need good health so parents can work and children can succeed at school. Elderly or disabled residents often have chronic conditions that require regular treatment if they are to enjoy the best possible quality of life.

By providing Internet access, Neighborhood Networks centers make it possible for residents to go online to get up-to-date information about specific diseases, eligibility for health insurance, drug discount programs, and other health matters. Centers also distribute health information, sponsor health fairs, or inform residents about government health insurance programs for which they qualify. In addition, in partnership with local hospitals, agencies, or nonprofit groups, Neighborhood Networks centers may participate in ongoing health programs or sponsor periodic health screenings, vaccinations for children, exercise or smoking cessation classes, and a variety of other activities.

### **Identify Residents' Needs**

What health programs do residents need? What do they want? How many people might show up for a high blood pressure check, to get a flu shot, or to find out about new prescription discount programs? For answers to these questions, it is necessary to ask residents directly and to talk to people who know and work with them.

As a starting point, demographic data compiled by property managers can provide a basic count of children and adults in a development. To get an indication of interest in a particular activity, place a sign-up sheet in the property management office or a flyer under unit doors. If a formal survey of resident needs is planned, be sure to include questions on health insurance coverage and interest in particular services.

Talk with people who work with residents, such as property managers, leaders of resident organizations, Neighborhood Networks staff, HUD Service Coordinators, staff of local clinics or emergency rooms, teachers at local schools, and staff of nearby churches and religious institutions.

Ask such questions as: What do you see as the most significant health problems for residents? Roughly what proportion of eligible residents would you estimate are actually signed up for Medicaid, Medicare, or the children's health insurance program in the state? Do you see healthcare problems as a barrier to parents working or training? Do families moving from welfare to work have difficulties obtaining health insurance? Do residents have access to dental services or other specialized care?

Talk about the causes of problems. Can residents afford care? Do they face transportation barriers or language difficulties? Are residents discouraged by the complexity of health programs? Do they know where to seek help?

Take notes and summarize the information in writing, both to better understand resident healthcare needs and to explain these needs to potential community partners.

### **Identify Community Resources**

Most health-related activities involve bringing in resources, such as public health services, government health insurance coverage, local health facilities, and community groups. National organizations and their local affiliates may provide information and other assistance online or over the telephone.

**Taking a community survey of health resources.** Brainstorm with the resident service

### Linking Residents to Healthcare Resources

council, property managers, Neighborhood Networks staff, HUD Service Coordinators, community leaders, school system health workers, elected officials, and others. Check local phone books and online search engines. Make a list of resources, including local hospitals and clinics; city or county health agencies; local chapters of national medical and health service organizations; charities interested in health and nutrition issues; and local gyms, fitness programs, food retailers, or weight-loss programs. These resources might be willing to take part in a project to benefit community residents.

**Helping residents with healthcare costs.** Many state and federal programs exist to provide health insurance for low-income people and lower the cost of prescription drugs, especially for the elderly.

- **Medicaid**, a federal health insurance program, pays for medical assistance for certain individuals and families with low incomes ([www.cms.hhs.gov/medicaid/consumer.asp](http://www.cms.hhs.gov/medicaid/consumer.asp)).
- **Medicare**, a federal health insurance program, pays for hospital and medical expenses for elderly people (age 65+) or for people with certain disabilities or conditions ([www.medicare.gov/default.asp](http://www.medicare.gov/default.asp)).
- **State Children's Health Insurance Program (CHIP)**, a set of state-operated programs, provides health insurance for children, up to age 19, who are not otherwise insured ([www.cms.hhs.gov/schip/consumers\\_default.asp](http://www.cms.hhs.gov/schip/consumers_default.asp) or [www.insurekidsnow.gov/](http://www.insurekidsnow.gov/)).
- **Head Start**, a federal early childhood education program, also provides health screenings, evaluation, and service coordination for low-income children ([www.acf.hhs.gov/programs/hsb/about/index.htm](http://www.acf.hhs.gov/programs/hsb/about/index.htm)).
- **BenefitsCheckup**, an online screening service operated by National Council on Aging initiated through a HUD partnership in 2000, helps people ages 55+ find out if they are eligible for various programs that help with some costs of prescription drugs, healthcare, utilities, and other essential items or services ([www.benefitscheckup.org/](http://www.benefitscheckup.org/)).

- **BenefitsCheckupRx**, an online screening service operated by the Access to Benefits Coalition (ABC), helps people decide among various prescription discounts such as the Medicare-approved drug card, state pharmacy programs, and other prescription assistance programs. ABC's Organizational Edition trains community groups in expert use of the screening tool (<http://bcuoe2.benefitscheckup.org/frmwelcome2.cfm?cfid=91396&cfToken=33025978>).

### **Market to and Develop Partners**

For health-related programs, community partners can provide visits by skilled staff or mobile diagnostic equipment, expertise, information, volunteers, or donations of supplies. Neighborhood Networks centers bring to the partnership access to an underserved community, a reliable point of contact, and a potential space to hold health activities.

Approach potential partners with a variety of ideas, solid information about community needs, and a willingness to learn what they may be able to provide.

### **Establish a Program**

Structure health projects or programs to respond to local needs and available resources.

- Define how the program will be organized and carried out, specifying the roles of resident service council members, property managers, and other in-house stakeholders.
- Establish goals with measurable outcomes such as the number of potential partners to approach, volunteers to involve, residents to serve, dates for visits by diagnostic vans, and progress milestones.
- Identify where necessary resources (staffing, equipment, and supplies) will come from.

- Be clear about how the program will deal with accessibility and security issues.
- Establish a mechanism to deal with unexpected problems.
- Follow up with thank-you letters to all community partners after the project.

## Market Programs to Residents

Market health events and services to residents through announcements in the property management office, Neighborhood Networks center, and places where residents visit. Distribute flyers to units by mail or by going door to door.

Publicity aimed at the wider community will also resonate with residents. Mail flyers to school principals, clergy, elected officials, heads of local nonprofits, and other community leaders. Send out a press release to local radio, television, newspapers, and "shoppers" newspapers. Community partners may have media expertise and be willing to share in the publicity work.

## Assess Outcomes and Revise Programs as Needed

At the completion of a health project, prepare a written summary report, including information such as:

- Project or event: date(s), purpose of event, number of people served.
- Internal information: Who did what? What roles did the resident council, Neighborhood Networks center, and property manager play? Note names and contact information of key people.
- Partnership information: names of partner organizations with contact information of key people.
- Successes: Did the project meet or exceed the measurable goals set?
- Problems: What problems emerged or what should people look out for in the future?

Consider how to share evaluation findings with residents, staff, partners, and other stakeholders. To help assess and track their health programs, centers can use START—HUD's Strategic Tracking and Reporting Tool. Using this online tool, Neighborhood Networks centers can complete annual assessments of their health programs and other activities based on the center's business plan projections. A large health program may call for a formal evaluation. Local colleges may supply student volunteers to plan and carry out an evaluation under faculty supervision.

### Examples of Health-Related Activities at NN Centers

**Crescent Park Multi-Cultural Family Resource Center** (Richmond, California) developed a partnership with HOPE for Kids in a 2000 event to deliver information about the California Healthy Kids initiative to all units while volunteers answered questions. In the fall of 2004, the center made available confidential HIV/AIDS testing and hosted an information session on county health and other resources for seniors. Currently, the center is establishing partnerships with First 5 to use Contra Costa County cigarette tax funds to provide health resources to children ages 0–5 and also with Doctor's Medical Center on a health and wellness program for families in HUD-assisted housing. Contact: Leonard McNeil, director, (510) 232-7424, ext. 11, [lmcneil@eahhousing.org](mailto:lmcneil@eahhousing.org).

**Houston Neighborhood Networks, Inc.**, a nonprofit consortium of Houston centers, developed a partnership with Preventive Healthcare Outreach, Inc., and St. Joseph's Hospital in 2003 to provide onsite comprehensive medical services to families and senior citizens at five Neighborhood Networks centers. In 2004 Preventive Healthcare Outreach continues to provide onsite health fairs offering preventive healthcare services to residents through Neighborhood Networks centers and at other HUD-subsidized multifamily complexes. Contact: Mary Frances Byrd, Neighborhood Networks Coordinator, (713) 718-3174, [Mary\\_Frances\\_Byrd@hud.gov](mailto:Mary_Frances_Byrd@hud.gov).

## Online Resources

Using the Internet, residents can learn about diseases and how they are treated, clinical trials for new medicines and treatments,

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*Linking Residents to Healthcare Resources*

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health insurance benefits, and alternative therapies. Residents can also join online support groups for families and contact local affiliates and support groups. *Note:* Exercise caution when using the Internet to research healthcare options, gather information, or take part in online forums, because not all information is reliable. Healthcare decisions should be made in consultation with a physician.

**General Health Information**

Healthfinder<sup>®</sup>, National Health Information Center,  
U.S. Department of Health and Human Services  
[www.healthfinder.gov](http://www.healthfinder.gov)  
Healthfinder<sup>®</sup> Kids  
[www.healthfinder.gov/kids/](http://www.healthfinder.gov/kids/)

National Institute on Aging—Age Pages  
[www.niapublications.org](http://www.niapublications.org)

Aetna Intellihealth  
[www.intelihealth.com](http://www.intelihealth.com)

*Better Health Magazine*  
Saint Rafael Health Systems  
[www.srhs.org/betterhealth.asp](http://www.srhs.org/betterhealth.asp)

Dr. Koop  
[www.drkoop.com](http://www.drkoop.com)

WebMD  
[www.webmd.com](http://www.webmd.com)

**Information on Specific Diseases**

Alzheimer's disease: Alzheimer's Association  
[www.alz.org](http://www.alz.org)

Arthritis: Arthritis Foundation  
[www.arthritis.org](http://www.arthritis.org)

Cancer: American Cancer Society  
[www.cancer.org](http://www.cancer.org)

Heart disease: American Heart Association  
[www.americanheart.org](http://www.americanheart.org)

Lung disease: American Lung Association  
[www.lungusa.org](http://www.lungusa.org)

Diabetes: American Diabetes Association  
[www.diabetes.org](http://www.diabetes.org)

Mental health: National Institute of Mental Health  
[www.nimh.nih.gov/healthinformation/  
index.cfm](http://www.nimh.nih.gov/healthinformation/index.cfm)

**Medical Research**

Centers for Disease Control  
[www.cdc.gov](http://www.cdc.gov)

Mayo Clinic  
[www.mayohealth.org](http://www.mayohealth.org)

National Institutes of Health  
[www.nih.gov/health](http://www.nih.gov/health)

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### List of Conferences

Calendar of conferences and training events.

### List of Resident Associations

List of Neighborhood Networks properties with active resident associations.

### Neighborhood Networks Consortia

List of Neighborhood Networks consortia.

### Senior Properties

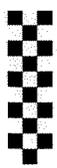
List of senior properties with operational Neighborhood Networks centers.

### Online Networking

Talk with Neighborhood Networks staff and stakeholders via online networking.

### Publications

- **Fact sheets.** Fact sheets are one-page summaries of various topics relevant to the operations of Neighborhood Networks centers. Fact sheets that are currently available include an overview of the Initiative, health information, childcare, transportation, seniors, and community improvements at Neighborhood Networks centers.
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Resources/Capabilities .....

Support Requested.....

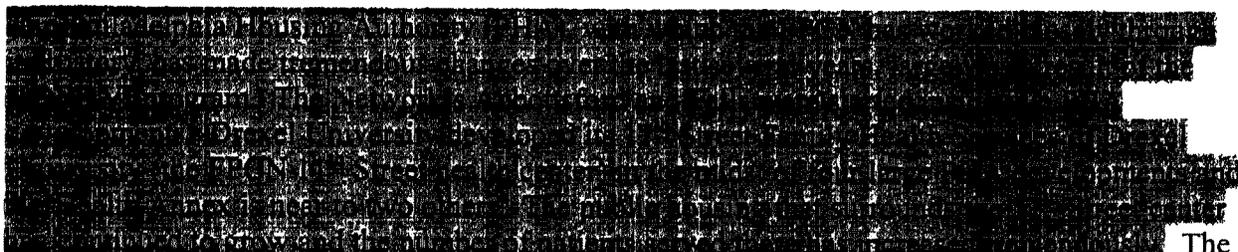
Governance.....

ExH 14

children, they often cannot afford child care and must bring children to appointments, and as noted in the article cited above, many have significant health problems that limit their mobility and include depression as well.

Nine percent of the HOPE VI households discussed in the article cited above had at least one child in fair or poor health, more than three times the figure for all children nationally. The prevalence of fair or poor health among HOPE VI children was significantly higher than national samples of poor children (6 percent) and black children (4 percent) under 18. About a quarter of the children in the HOPE VI Study survey had been diagnosed with asthma, a share about twice as high as national estimates for children in this age group.

**3. Special Population – Residents of Public Housing**



The housing development where the Falls health center was originally located was razed and replaced with much less dense housing. Several middle-class areas nearby have been expanding and the area has been increasingly gentrified. Over 60% of the Abbottsford Homes development has been razed and only 200 residents remain of the 1,200 that lived there two years ago and the 3,000 ten years ago. The future of that development remains unclear. The Falls center has lost its lease and the Philadelphia Housing Authority has not provided any support for the FPCN to expand the Abbottsford center's space. Therefore, a Change of Scope has been approved by HRSA for the Network to consolidate these two centers into one new center, which is four blocks from Abbottsford and 1.8 miles from the Falls site. The renovations are nearly complete and the new Abbottsford/Falls Health Center should be open by November 2007.

The Change of Scope also includes moving the FPCN Health Annex center in Southwest Philadelphia to a larger site in a busy shopping area that is five blocks from the current site and is easier to access from the public housing developments in the area. The new Health Annex is also almost complete and will be open by December 2007. It will include a badly needed dental center, as well as seven additional exam rooms and more behavioral health space. Outreach will be done in the housing developments before the center opens, to assure that residents know that the health center will be more convenient for them.

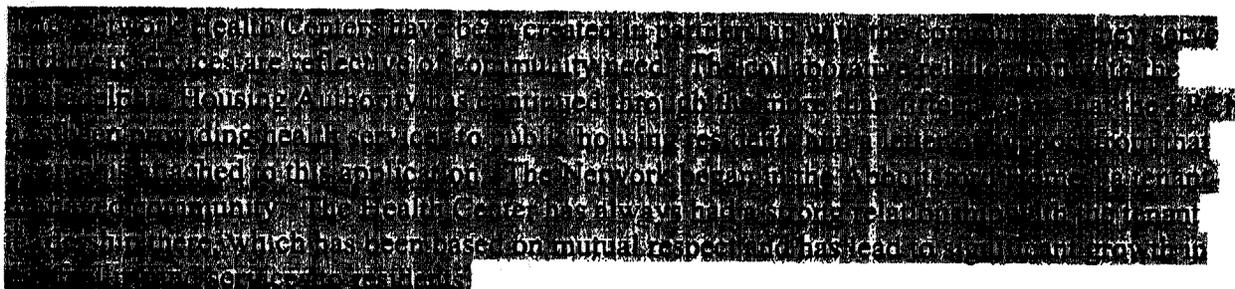
As a result of the changes made by PHA, many public housing residents have been relocated around the city. Many of these who were FPCN patients have continued to use their FPCN health center for their care. The FPCN uses Medicaid transportation resources, as well as its own vans, to assure that patients are able to travel to appointments at the Network centers and to specialist appointments elsewhere.

EXH 14

**2. Appropriateness and Responsiveness of Service Delivery and Public Housing Access**

**a. Locations and Activities**

By the beginning of 2008, the FPCN will have three sites: Abbottsford/Falls, 11<sup>th</sup> Street Family Health Services of Drexel University, and the new Health Annex. The current Abbottsford, Falls, and Health Annex sites will be closing (See Form 5-B). The Change of Scope for these changes has been approved by HRSA. All of the FPCN health center sites provide the full range of primary and preventive services, including emergency medical services; diagnostic testing and screening; HIV testing and counseling; pre-natal, obstetric, and midwifery services; hearing and vision testing; nutrition education; translation services, pharmacy; case management, including tracking for hospitalized patients; eligibility assistance; outreach services; and transportation assistance. Behavioral and substance abuse services and various health-related community and youth services are also provided in all three sites. Dental oral health services are available to all patients, although they will be provided only in the 11<sup>th</sup> Street and Health Annex sites.



*Abbottsford/Falls Health Center* – The new Abbottsford/Falls Health Center site will be co-located with the administrative offices of the FPCN, very near to the central office of RHD. This site is four blocks from the Abbottsford site and 1.8 miles from the Falls site that are closing (See Attachment 2: Service Area Map). The new site will have 10 examining rooms, two more than the current two sites combined. It will also have eight behavioral health rooms. Patients who need assistance coming to the new site, particularly those at Abbottsford Homes who have mobility difficulties, will be helped to access Medicaid transportation or will be transported by FPCN van, particularly in the period after the old site closes. The new site is close to additional public housing developments that have not been specifically served before and outreach will be done in those to assure that residents are aware of the new health center and the services available. All primary and preventive care will be provided on-site, including podiatry, nutritionist services, behavioral health, and support groups such as one for women with depression. Dental services will be provided by referral to the two FPCN dental sites at 11<sup>th</sup> Street and the Health Annex, or to other providers. Radiology, medical specialty, and hospital emergency care and acute care services are provided by referral.

*11<sup>th</sup> Street Health Center* – The 11<sup>th</sup> Street Family Health Services of Drexel University became part of the Family Practice and Counseling Network at the same time that its new facility opened in 2002. It had been in operation since 1998 in a smaller facility nearby. 11<sup>th</sup> Street is operated under an agreement with Drexel University College of Nursing and Health Professions, which provides much of the staffing for the center. The 11<sup>th</sup> Street center is located in an area of North Philadelphia that is known in public housing circles as the 11<sup>th</sup> Street Corridor because of the concentration of public housing located there. A study revealed that many people in the area had

## Creating a Health Program at Your Center



### Objectives

You will learn how:

- ◆ To create health programs for Neighborhood Networks centers.
- ◆ To develop community/neighborhood health partnerships.
- ◆ To use the Internet to access quality health information.

### Key Points

- ◆ Health challenges in Neighborhood Networks communities.
- ◆ Introduction to potential health care and health education partners.
- ◆ Using the Internet to obtain reliable health information.

EXHIBIT 17

*2002 Regional Technical Assistance Workshop*

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## Public Housing Primary Care Program

The Public Housing Primary Care (PHPC) Program is a federal grant program created under the Disadvantaged Minority Health Improvement Act of 1990. In 1996, the PHPC Program was reauthorized under the Health Centers Consolidation Act as Section 330(i) of the Public Health Service Act.

### Mission

To improve the health and well-being of the public housing community, moving toward 100 percent access and zero disparities.

The public housing community (our target population) includes:

- Residents of public housing.
- Low-income individuals living in areas accessible to public housing.
- Any low-income person who benefits from public rent subsidies.

### Activities

The PHPC Program supports health centers and other health delivery systems in providing services in partnership with other community-based providers of public housing developments or at other locations immediately accessible to residents of public housing. PHPC grantees perform the following activities:

- Provide primary health care services, including direct medical care, health screening, health education, dental care, prenatal and perinatal care, preventive health care, and case management.
- Conduct outreach services to inform residents about health services that are available.
- Aid residents in establishing eligibility for assistance under entitlement programs and obtaining government support for health, mental health, or social services.
- Train and employ residents of public housing to provide health screenings and health education services.

### Accomplishments

In Fiscal Year 2001, 29 PHPC grantees in 16 States were awarded program funds to provide primary health care services. Highlights of program activity include:

- More than 53,000 clients were served. Major health conditions presented by clients were hypertension, asthma, diabetes, ear infections, chronic emphysema, and severe mental disorders. More than 175,000 medical and dental encounters were provided.
- PHPC programs have increased immunization rates for children ages 0-6 to over 95 percent. Several programs have achieved a 100 percent immunization rate.
- PHPC programs have established highly effective partnerships with public housing authorities and resident/tenant organizations to facilitate the delivery of services. Residents themselves are actively involved in the design of services and governance of programs, and residents are routinely trained and employed in the programs as outreach workers and case managers.
- Thirty percent of PHPC grantees are participating in collaborative and comparable activities to improve and expand the scope of their services.

**Collaborative Linkages**

Organizations that work with the PHPC Program to support the program mission include:

- U.S. Department of Housing and Urban Development
- Centers for Disease Control and Prevention
- Child Welfare League of America
- Administration for Children and Families
- HRSA's HIV/AIDS Bureau
- Local Housing Authorities

**Appropriations**

FY 2000 \$11.5 million  
 FY 2001 \$14.13 million  
 FY 2002 \$15.7 million

**Future Challenges**

PHPC is challenged to adapt to a rapidly changing public housing environment comprising mixed income families. Also, the PHPC is learning how to comprehensively serve an emerging immigrant population in a culturally proficient manner. In order to meet these goals, the PHPC continues to develop and strengthen its partnerships with organizations in the fields of health, public housing, and employment.

**For More Information, Contact:**

Public Housing Primary Care Program  
 Division of Programs for Special Populations  
 Bureau of Primary Health Care  
 4350 East-West Highway, 9th Floor  
 Bethesda, MD 20814  
 (301) 594-4420  
 (301) 594-2470 (fax)

**Who We Serve: PHPC's Clients****Demographics of Residents of Public Housing**

- More than 3.1 million individuals
- 2.4 individuals per household
- \$8,900 average household income
- 68 percent minority
- 48 percent 62 years old/disabled
- 48 percent with children under age 18 years old

**Patient Demographics**

- Approximately 54,000 served per year
- 18.6 percent increase in patients
- 62 percent female, 38 percent male
- 29 percent children 1-12 years, 47 percent adults 20-64 years
- 77 percent increase in elderly

2002 Regional Technical Assistance Workshop

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- 47 percent increase in AAPIs, 35 percent increase in Hispanics
- 114 percent increase in need for language interpretation services

**Patient Socioeconomics**

- 65 percent below 100 percent of the federal poverty level
- 50 percent Medicaid, 33 percent uninsured

**Patient Diagnoses and Services**

- Hypertension (44 percent increase)
- Severe mental disorders (30 percent increase)
- Otitis media and eustachian tube disorder
- Diabetes (46 percent increase)
- Asthma

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**10-92 COVERAGE AND EXCLUSIONS 433.3****HIM 27 RHC/FQHC Manual**

ambulance company charges non-residents to the extent they are able to pay (e.g., through private insurance) the free services provided the residents are excluded from coverage while the services furnished non-residents are covered.

**433. ITEMS AND SERVICES FURNISHED OR PAID FOR BY GOVERNMENT INSTRUMENTALITIES**

The Medicare law places limitations on the circumstances under which payment may be made for items and services furnished or paid for by State, local or Federal Government instrumentalities. **However, §1862(a)(3) of the Act permits payment to FQHCs for services to beneficiaries that are paid for directly or indirectly by a governmental entity.**

**With the exception of items and services provided by FQHCs, the law contains separate limitations applicable to Federal providers of services (see §433.1), items and services which the provider or supplier is obligated under a Federal Government contract or law to furnish at public expense (see §433.2), and items and services paid for directly or indirectly by a government entity (State, Federal, or local). (See §433.3.)**

The following sections discuss these limitations in greater detail and how they are to be applied under various circumstances.

**433.1 Payment to Federal Provider of Services or Other Federal Agency.--**Payment may not be made to a Federal provider of services or other Federal agency unless the services are (a) emergency inpatient services, or (b) items and services furnished by a Federal provider which is determined by the Secretary to be providing services to the public generally as a community institution or agency.

For the purpose of this exclusion, a provider or other facility acquired by the Department of Housing and Urban Development (DHUD) in the administration of an Federal Housing Administration mortgage insurance program is not considered to be a Federal provider or agency. Accordingly, Medicare payment may be made for services furnished by such DHUD owned facilities.

**433.2 Items and Services Which Provider or Supplier Is Obligated to Furnish Under Federal Government Contract or Law.--**Payment may not be made for items or services which a provider or other person is obligated by law of, or contract with, the United States to render at public expense.

**433.3 Items and Services Which are Paid Directly or Indirectly by Government Entity.--**

A. **General.**--Benefits are not payable under Medicare Part A or B for items and services paid for by an agency of a State or local government or of the Federal Government, except as specified in subsections B and C. This exclusion applies to services furnished by government operated facilities as well as services furnished by non-governmental facilities which are paid for by a governmental agency.

B. **Statutory Exceptions.**-- The exclusion of items and services paid for by a governmental entity does not apply in the following situations. Therefore, payment may be made under Medicare where:

- o **The items or services are furnished by an RHC or an FQHC;**
- o The items or services are furnished under a health benefits or insurance plan established for employees of the governmental entity;

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- o The items or services are furnished under one of the titles of the Social Security Act (such as medical assistance under title XVI of XIX).

C. **Exceptions Approved by the Secretary.**--The Secretary of Health and Human Services is authorized by law to specify additional exceptions to this exclusion. The Secretary has approved Medicare payment for services provided or paid for by a governmental entity in the following additional situations:

- o The items or services are furnished by a participating State or local government-operated hospital, including a psychiatric or tuberculosis hospital, which serves the general community. A psychiatric hospital to which patients convicted of crimes are committed involuntarily is considered to be servicing the general community if State law provides for voluntary commitment to the institution. However, payment may not be made for services furnished in State or local hospitals which serve only a special category of the population, but do not serve the general community, e.g., prison hospitals; and
- o The items or services are paid for by a State or local government entity and furnished an individual as a means of controlling infectious diseases or because the individual is medically indigent. These services need not be furnished in or by a hospital.

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<b>Resources for Human Development</b>	
<b>Analysis of Imputed Rent and Utility Costs</b>	
<b>FY 1999 Cost Report</b>	
25,584	Abbottsford rent The health center took over 4 apartments in the public housing development. The monthly rent charged by Phila Housing Authority for each apartment had been \$533. The imputed rent was calculated at \$533 X 4 apts X 12 months.
8,443	Schuylkill Falls rent A community activity area of the public housing development was converted into the Schuylkill Falls Health Center. This area was 1/3 the size of the Abbottsford Health Center and the imputed rent was therefore calculated at 1/3 the rent amount of Abbottsford.
2,664	Schuylkill Falls utilities The Phila Housing Authority charged utilities at Abbottsford in the amount of \$666/month. The imputed utility cost at Schuylkill Falls was therefore calculated at 1/3 the Abbottsford amount.
36,691	Total Imputed Costs - FY 1999
<b>FY 2000 Cost Report</b>	
25,584	Abbottsford rent The health center took over 4 apartments in the public housing development. The monthly rent charged by Phila Housing Authority for each apartment had been \$533. The imputed rent was calculated at \$533 X 4 apts X 12 months.
16,707	Schuylkill Falls rent Phila Housing Authority received a HUD grant to renovate the development which included the demolition of the health center building. The health center moved out of the PHA building into trailers on the property while seeking permanent space. The cost of the trailers and storage space was \$16,7607. RHD paid this amount to the vendors and later received reimbursement from PHA.
(8,926)	Paid to PHA
33,365	Total Imputed Costs - FY 2000

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# Martin Luther King



Martin Luther King  
Living Room

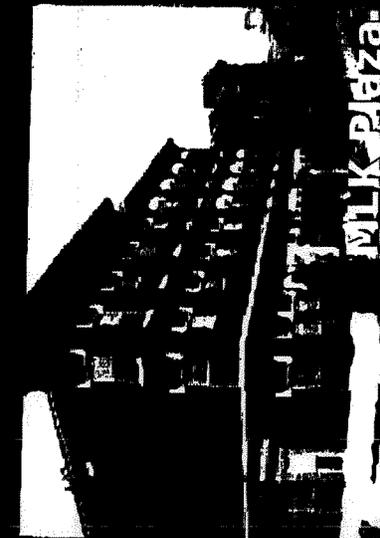
## Budget

HOPE VI	\$25.2 million
PHA Capital Funds	4 million
City Capital Funds	3.1 million
9% LIHTC Equity	15.5 million
First Mortgage	8 million
Other	<u>18.2 million</u>
<b>Total Investment:</b>	<b>\$74 million</b>

# Bringing Value to Neighborhoods

PHA has dramatically increased neighborhood property values near our sites.

Sales prices were studied in these neighborhoods:



**Increases in these neighborhoods exceeded the citywide average**