BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

Program, Policy, & Appeals Committee Members:
Commissioner Stoll (Chair)
Commissioner Shaffer
Commissioner Leininger

BOARD OF HEALTH – PROGRAM, POLICY, & APPEALS COMMITTEE
Agenda for February 18, 2026 at 8:30 AM

1. Call to Order
   a. Roll Call
   b. Approval of the Agenda

2. Public Comment

3. Unfinished Business
   a.

4. New Business
   a. Quality Improvement Plan – pg 2
   b. Cost Allocation Plan – pg 19

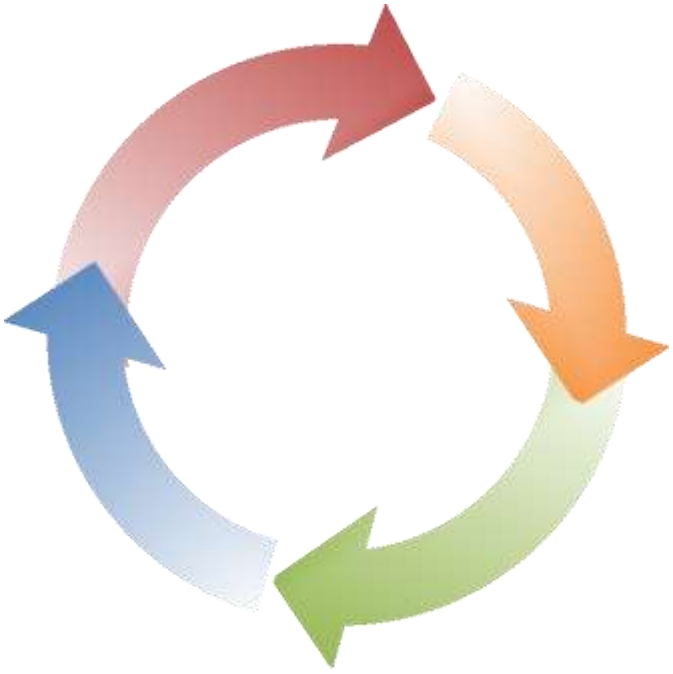
5. Public Comment

6. Adjournment - Next meeting: Full Board meets February 26, 2026. PPA next meeting is scheduled for March 18, 2026

Public Comment:
For the purpose of public participation during public hearings or during the public comment portion of a meeting, every speaker prior to the beginning of the meeting is requested but not required to provide the Board with his or her name, address and subject to be discussed. Speakers are requested to provide comments that are civil and respectful. Each speaker will be allowed to speak for no more than three (3) minutes at each public comment opportunity.

Branch-Hillsdale-St. Joseph Community Health Agency

Quality Improvement Plan 2026-2029



Updates to the BHSJ CHA Quality Improvement Plan

Revision Date	Update	Page #s	Approved by

Table of Contents

Table of Contents

Branch-Hillsdale-St. Joseph Community Health Agency
Quality Improvement Plan

Section I: Purpose

The purpose of the Branch-Hillsdale-St. Joseph Community Health Agency (BHSJ CHA) Quality Improvement Plan is to provide guidance for BHSJ CHA's Quality Improvement (QI) efforts. The plan provides a framework for QI processes and activities as well as a plan to measure and monitor the Agency's progress towards QI goals.

Section II: Overview of Quality

Quality in public health is the result of worthy work well-done. Quality is achieved when the work of the Agency is based on science and the best available evidence (worthy); is linked with the health outcomes that are most important to the agency and the communities served (work); and is performed in an acceptable manner, often defined by specific standards (well-done).

BHSJ CHA has an interest in systematically evaluating and improving the quality of programs, processes, and services to achieve a high level of efficiency, effectiveness, and customer satisfaction. Thus, implementation of a Quality Improvement culture throughout BHSJ CHA will contribute to the Agency's overall goal to protect and improve the health of the population. Our vision for the future state of quality is "An agency that utilizes continuous quality improvement at all levels to achieve our mission of helping people live healthier."

Section III: QI Governance Structure

A. Organization Structure

1. Quality Improvement & Accreditation Program (QIAP)

The Quality Improvement & Accreditation Program serves as the overarching leader for quality improvement and performance improvement activities throughout the Department. QIAP provides oversight, coordination, training, technical assistance, and data management for all BHSJ CHA programs.

2. Quality Improvement (QI) Advisory Committee

The QI Advisory Committee was established to assist QIAP in managing QI efforts across BHSJ CHA. The QI Advisory Committee is made up of representatives from all programs or divisions within the agency, including Administration, Area Agency on Aging, Environmental Health, Health Education and Promotion, and Personal Health & Disease Prevention. Every effort will be made to have representation from all levels of employment. They meet no less than quarterly to discuss QI initiatives, projects, and to learn about QI tools. (See Appendix A for the QI Advisory Committee.)

B. Roles and Responsibilities

1. Health Officer and Board of Health

a. Provide leadership to achieve the BHSJ CHA's vision, mission, strategic plan, and direction related to QI efforts.
b. Promote and support a culture of QI in BHSJ CHA.
c. Promote and support QI efforts and initiatives.

2. Quality Improvement & Accreditation Program

a. Provide direction for QI efforts throughout the Agency, including the facilitation of an Agency-wide QI Advisory Committee to coordinate QI efforts.
b. Oversee the development and implementation of the QI Plan.
c. Provide training, consultation, and technical assistance for QI efforts
d. Ensure communication of QI activities and QI project results to the Executive Team and Health Officer.
e. Promote and support a culture of QI in BHSJ CHA.

3. Division Directors

a. Support the implementation of QI projects:
    - Identify QIAC members to lead QI projects within the divisions or programs.
    - Assist in identifying resources for QI projects and public health measures for tracking.
    - Assure that QI projects advance the Program, Division, and Department goals, objectives, and strategic plans.
b. Provide the QIAC members and project teams with opportunities to share their findings through staff meetings.
c. Promote and support a culture of QI in BHSJ CHA.

4. Managers/Supervisors

a. Develop an understanding of QI principles & tools.
b. Assure and support staff participation in QI activities as needed.
c. Lead program-level QI projects as needed.
d. Promote and support a culture of QI in BHSJ CHA.

5. Quality Improvement Advisory Committee (QIAC)

a. Participate in Department-wide QI activities.
b. Assist in the development and refinement of the program's population indicators and performance measures.
c. Participate in and or lead division- or program-level QI projects.
d. Monitor performance of division- or program-level QI projects.
e. Provide recommendations, expertise, and guidance to QI project teams.
f. Serve as a liaison between the QIAC and their program.
g. Advocate for QI practices and support a culture of QI in BHSJ CHA.

6. All Staff

a. Develop an understanding of basic QI principles and tools.
b. Become familiar with their program's public health measures.
c. Identify program areas for improvement and suggest improvement actions to the QIAC members.
d. Participate in QI activities as needed.

Section IV: Staff Training and Resources

A. New Staff

New departmental staff will receive an orientation and training in QI processes at BHSJ CHA within the first 6 months of employment. During this orientation, new employees will learn basic QI terminology and principles as well as receive an overview of the Department's QI infrastructure, including their role in QI projects. Quality Improvement is also covered in the required *Public Health 101* training.

New supervisors will be required to take an additional 4-hours of Quality Improvement training after completion of their ICS courses.

B. Current Staff

The Quality Improvement Advisory Committee will annually select a course for required training of all staff by September 30 of each year.

Additionally, there are links to three introductory QI trainings available to all staff in BHSJ CHA on the MITrain website. These trainings could include any of the following courses:

1. *Introduction to Quality Improvement in Public Health*, by the Public Health Foundation (30 minutes) – This course is required for all staff in 2025-2026
2. *CQI for Public Health: The Fundamentals*, by The Ohio State University College of Public Health (2 hours)
3. *Quality Improvement Quick Guide Tutorial*, by the Public Health Foundation (45 minutes)

In addition to the web-based courses, education on QI tools and principles will be added to existing BHSJ CHA trainings sponsored by the agency.

C. QI Advisory Committee

In addition to the educational opportunities listed above, QIAC members will receive ongoing specialized training in various QI methods and tools at quarterly QIAC meetings. The QIAC members also have an opportunity to enroll in additional QI trainings approved by their Division Director and paid for by BHSJ CHA.

D. QI Support

QIAP provides support to programs to carry out QI activities (i.e., develop and manage public health measures as well as implement QI projects). Programs can request guidance or technical assistance. The following examples represent common support request topics: designing meaningful public health measures using Results-Based Accountability, using QI tools, updating public health measures, prioritizing and selecting a Quality improvement project, implementing a QI project plan using the PDCA process, and designing PDCA test cycles and completing storyboards.

E. Tools and Resources

QIAP maintains a library of QI templates, forms, and reference materials that are available to QIAC members and program staff on the agency shared drive: M:\Operations\Quality Improvement.

Section V: BHSJ CHA Quality Management System and Activities

A. Quality Management System Overview

In 2002, the Turning Point Performance Management National Excellence Collaborative developed a Performance Management System Framework (Figure 1). This framework serves as the basis for BHSJ CHA's QI efforts and is referred to as the Quality Management System in BHSJ CHA.

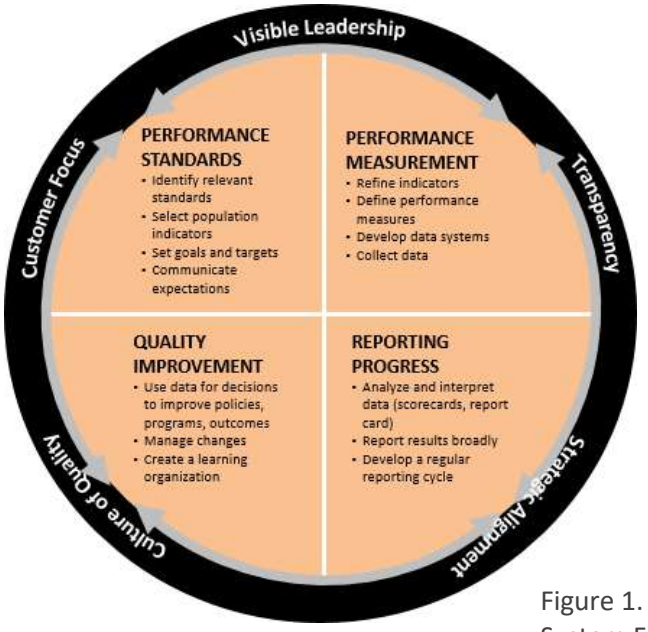


Figure 1. Performance Management System Framework

BHSJ CHA's QI activities are organized by the four components of the Quality Management System (QMS). [1] Within each component, BHSJ CHA follows a structure and timeframe to guide the implementation of the Department's QI efforts:

1) Performance Standards & 2) Performance Measurement

BHSJ CHA follows the Results-Based Accountability Framework to develop a set of Public Health Measures. These measures are reviewed and **updated annually**. Public Health Measures are tracked through the County Health Rankings.

3) Reporting Progress

BHSJ CHA programs collect data for all Public Health Measures **annually.** Reports from our performance management system are generated and shared among BHSJ CHA leaders.

4) Quality Improvement

BHSJ CHA uses the **Plan-Do-Check-Act** Cycle to guide QI projects as needed (**ongoing basis).**

B. Description of QI Activities

1) Performance Standards are organizational or system goals, standards, and targets to improve public health practices.

2) Performance Measurement is used to assess achievement of performance standards.

Each program or division in BHSJ CHA has a set of **Public Health Measures,** which includes both performance standards and performance measures.

- Public Health Measures are structured according to the accreditation standards.
- QIAC members work with their programs to update their Public Health Measures are annually.
- The Public Health Measures and data are tracked our performance management system.

There are two categories of measures: population health and program performance. Thus, BHSJ CHA's Public Health Measures includes two levels of measures: Population Indicators **and** Performance Measures**.** [2]

1. **Population Indicators** reflect a measurement of the population's condition or well-being. The indicators are influenced by many factors outside the direct control of our Agency, thus accountability for these measures is often shared by a group of partners.

2. **Performance Measures** measure how well a program, agency or system is working. It focuses on the work performed by the agency and are collected at the program-level.

Other Definitions

Public Health Measures also include targets and goals:

Targets are chosen by each program as measurement goalposts in the progress towards reaching standards. Targets are based on realistic expectations of how far a program is able to move each year or they may be based on national, state, scientific guidelines or other benchmarks.

Goals are identified by each program to identify a unified purpose that embodies the priorities each program will work on for that strategic planning cycle.

3) Reporting Progress is the documentation and reporting of how targets are met through appropriate feedback channels.

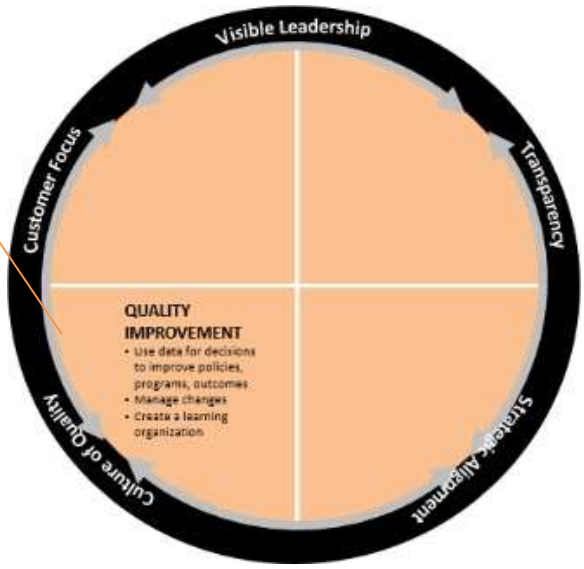
Each BHSJ CHA program collects data for their Public Health Measures annually and enters the information in our performance management system.

The data is compared against the program's target and data from previous years. The results are provided in our performance management system's reports and discussed quarterly by the QIAC.
Currently, data is reported either annually or quarterly, depending on the measure.

4) Quality Improvement is a process to manage improvement efforts.

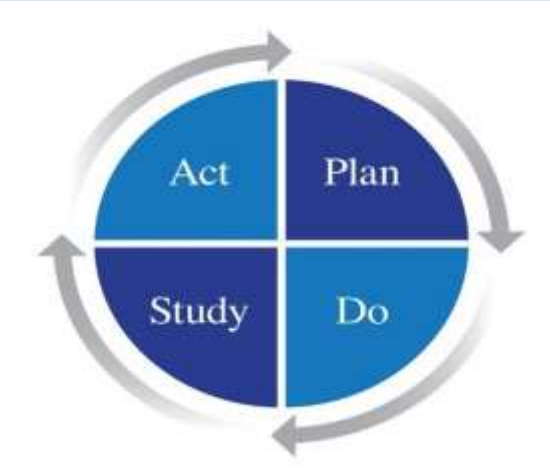
In this component, QIAP encourages programs to conduct QI projects to address areas or opportunities for improvement as needed.

To guide QI projects, QIAP encourages programs to follow the **Plan-Do-Check-Act** Cycle, a process for testing changes that can lead to improvements (Figure 2).



Through the QI Team, QIAP also creates opportunities for QIAC members to learn from one another. Additionally, an annual QI Summit is convened by QIAP to bring together the Department's leaders and QIAC members to discuss QI efforts across the BHSJ CHA.

Plan-Do-Check-Act (PDCA) Cycle



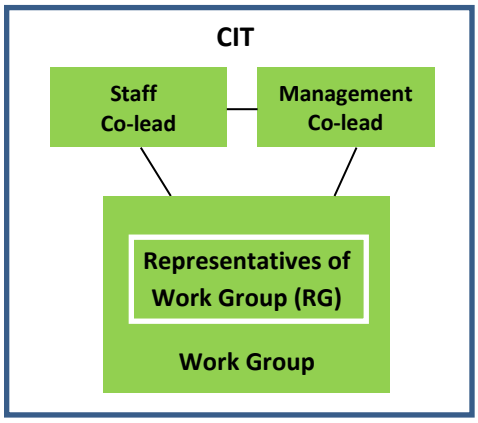
The PDCA Cycle (also known as the PDSA or Deming Cycle) is a systematic process for continuous learning and improvement.

A **"Plan"** for testing changes or new strategies is developed, followed by completing the activities as planned **("Do"**). Outcomes are monitored for signs of progress **("Check")** and based on what is learned, the next steps are planned **("Act").** These steps can be completed in a rapid cycle and repeated over and over for continuous learning and improvement. (https://deming.org)

All Programs within BSHJ CHA are encouraged to implement rapid-cycle PDCA projects to continuously assess and improve the quality of the Department's programs and services.

Continuous Improvement Teams

A CIT is a team that brings frontline workers and managers together to make program or system changes to improve day-to-day operations in the work environment. CITs strive to empower staff to help make improvements so that all clients can have a better experience. The CIT structure is based on a Partnership Model.



A pair of co-leads (one representing staff and one representing management) leads the CIT through a **collaborative** process where every member has a voice and an opportunity to contribute their ideas. (This CIT structure is supported by Staff and Management sponsors. A coach also supports the team's development.)

The team works together using quality and performance improvement methods and tools to set goals, establish metrics, identify problems, and make system changes, improvements and recommendations.

The following are benefits of CITs:

- Program or system changes that will lead to a better customer experience
- Cultural and relationship transformation – CITs give staff more opportunities to play a leadership role and contribute to changes in the workplace in a collaborative way
- Staff have opportunities to build leadership and team-building skills and quality and performance improvement expertise.

C. Culture of Quality Improvement

NACHHO's Roadmap to a Culture of Sustainable Quality Improvement

NACCHO's QI Culture Roadmap includes a self-assessment tool (SAT) to determine in which phase public health departments are in towards reaching a level of sustainable quality improvement implementation. As part of the QI Roadmap tool, NACCHO offers improvement strategies tailored to move health departments' scores from one level to the next higher level.

Branch-Hillsdale-St. Joseph Community Health Agency has trained all staff in quality improvement. New staff are trained within six months of hire. All divisions are expected to complete one QI project during each fiscal year. Projects are required to be documented in the agency's performance management system.

. Strategies for Continuous Process and Leadership foundational areas are listed in the table below:

Foundational Area	**Strategies**
Leadership	Routinely communicates the organization's QI vision and goals to staff
	Provides structure for staff to receive QI training and get involved in QI
	Provides the resources, training and staff time to effectively run improvement activities & projects
Continuous Process	Develop and document standardized work for key work processes
	Make developing/updating standardized work a required output of all process improvement efforts
Teamwork & Collaboration	Create teams that cut across all locations to spur innovation
	Make more visible QI projects completed, post in program/division offices
Employee Empowerment	Clearly define QI expectations of staff
	Make readily available beginner and advanced-level trainings & resources to accommodate both new and experienced staff
QI Infrastructure	Form a QI Leadership Committee
	–Representation from each division
	–Selects annual improvement areas
	Maintain the tracking of accreditation performance standards
Customer Focus	Analyze and use data from customer surveys for improvement in services
	Track improvements for the entire organization
	Share progress with staff

Section VI: BHSJ CHA QI Goals and Objectives (updated annually)

QIAP Public Health Measures

	Performance Goal 1: Building organizational capacity to apply QI processes and tools		
1.1	Percent of QIAC members who completed QI process training activities offered by the agency.		100%
1.2	One QIAC member completes the MPHI's QI Train the Trainer Course annually		1
1.3	Percent of Project Leads s with a performance management report regarding their QI project annually.		90%
1.4	Percent of employees who complete QI orientation training on time annually.		90%

	Performance Goal 2: Supporting the implementation of QI projects		
2.1	QIAP will provide 4 QI roundtable sessions to all staff by annually.		4
2.2	Percent of Project Leads that complete a QI Project annually.		90%

Section VII: Communication Strategies

The following communication strategies will be implemented to ensure clear and concise internal communication about the Agency's QI Plan.

A. Utilize existing communication venues such as the Health Officer's monthly meeting, Director & Supervisor meetings, BHSJ Insider, and the annual all staff meeting to:

1. Present the QI Plan to senior leaders with the expectation that they will share in their organizational units
2. Share findings from QI initiatives
3. Share successes and lessons learned

B. Utilize the performance management system to:

1. Post the QI Plan and revisions
2. Post QI tools and examples of tool application
3. Report out results at the annual all staff meeting

C. Utilize QIAC members

1. Report on QI Team activity at their program-level staff meetings
2. Teach QI tools to staff in their program
3. Report out results at the annual staff meeting

Section VIII: QI Plan Progress Evaluation

A. Quarterly

1. QIAP logs and tracks requests for technical assistance and QI training activities quarterly.
2. Project Leads and/or QIAC members submit quarterly updates on their QI projects using the performance management system.

B. Annually

1. The QI Plan will be evaluated by the QIAP Team during 1st quarter of the fiscal year to determine if any targets were met, as well as to provide input on new goals.

Section IX: Definitions

Continuous Improvement Teams :A CIT is a team that brings frontline workers and managers together to make program or system changes to improve day-to-day operations in the work environment.

Continuous Quality Improvement (CQI): is an ongoing effort to improve the efficiency, effectiveness, quality, or performance of services, processes, capacities, and outcomes. [3]

Plan-Do-Check-Act (PDCA): is an iterative four-stage problem-solving model for improving a process or carrying out change. PDCA stems from the scientific method (hypothesize, experiment, evaluate). A fundamental principle of PDCA is iteration. Once a hypothesis is supported or negated, executing the cycle again will extend what one has learned. [6]

Quality: Quality in public health is the result of worthy work well-done. Quality is achieved when the work of the agency is based on science and the best available evidence; is linked with the health outcomes that are most important to the agency and the communities served; and is performed in an acceptable manner, often defined by specific standards. [4]

Quality Improvement (QI): is an integrative process that links knowledge, structures, processes and outcomes to enhance quality throughout an organization. The intent is to improve the level of performance of key processes and outcomes within an organization. [3]

Quality Improvement Plan (QIP): identifies specific areas of current operational performance for improvement within the agency. The QIP and the Strategic Plan can and should cross-reference one another.

Quality Improvement Project Teams: program-level teams, organized to carry out QI activities, namely PDSA cycles. QI Project Teams, with assistance from the Quality Improvement & Accreditation Program, are charged with developing, implementing, evaluating and reporting on formal QI projects.

Quality Management: the strategic use of performance standards, measures, progress reports, and ongoing quality improvement efforts to ensure an agency achieves desired results. [3]

Quality Management System: the continuous use of quality management practices so that they are integrated into an agency's core operations. [1]

Quality methods: builds on an assessment component in which a group of selected indicators are regularly tracked and reported. The data should be regularly analyzed. The indicators show whether

agency goals and objectives are being achieved and can be used to identify opportunities for improvement. Once selected for improvement, the agency develops and implements interventions, and re-measures to determine if interventions were effective. [3]

Quality Tools: are designed to assist a team when solving a defined problem or project. Tools will help the team get a better understanding of a problem or process they are investigating or analyzing. [6]

Strategic planning and Program planning and evaluation: Generally, the Department's Strategic Plan and QI Plan encompass strategic planning and QI activities that occur at the level of the overall organization, while Program planning and evaluation are program-specific activities that feed into the Department's Strategic Plan and QI Plan. Program evaluation alone does not equate with QI unless program evaluation data are used to design program improvements and to measure the results of the improvements as implemented. [3]

Section X: References

1. Public Health Foundation. (2002). *From Silos to Systems: Using Performance Management to Improve the Public's Health*.

2. Friedman, M. (2005).*Trying Hard is not Good Enough: How to Produce Measurable Improvements for Customers and Communities*. FPSI Publishing.

3. Public Health Accreditation Board. (2013). *PHAB Acronyms and Glossary of Terms Version 1.5*. Retrieved from http://www.phaboard.org/wp-content/uploads/FINAL_PHAB-Acronyms-and-Glossary-of-Terms-Version-1.5.pdf.

4. Gunzenhauser, J.D. (2012, May). *Quality Improvement in Public Health Practice. Quality Improvement Summit.* Lecture conducted from California Endowment Center, Los Angeles, CA.

5. Centers for Disease Control and Prevention. (2008) Office of the Chief of Public Health Practice, National Public Health Performance Standards Program. Retrieved from http://www.cdc.gov/nphpsp/performanceImprovement.html.

6. Bialek, R., Duffy, G. L., & Moran, J. W. (2009). *The Public Health Quality Improvement Handbook*. Milwaukee, WI: Quality Press.

7. National Association of County and City Health Officials (2024). Quality Improvement Additional Resources. Retrieved from *https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/quality-improvement*

Section XI: Appendices

Appendix A: QI ADVISORY COMMITTEE Charter

Branch-Hillsdale-St. Joseph
Community Health Agency
QI ADVISORY COMMITTEE CHARTER

Vision

A public health department where: 1) Staff are empowered to identify areas of improvement and find solutions through the application of Quality Improvement tools; and 2) leaders use public health measures for decision-making.

Mission

To train & assist staff to measure and improve the implementation and impact of their program activities.

Goals

1) To build organizational capacity for the application of QI processes and tools
2) To support the implementation of QI projects
3) To lead BHSJ CHA's efforts to obtain and maintain public health accreditation

Role of QI Accreditation Program (QIAP)

- Convenes and facilitates meetings for the Agency-wide QIAC
- Provides access to beginning and intermediate QI training
- Facilitates the development, implementation, and revision of the Agency's QI Plan
- Orients QIAC members to the performance management system
- Provides consultation & technical assistance to QIAC
- Plans and facilitates Agency Roundtable discussions

Role of QI Advisory Committee[2]

- Serve as liaisons between CITs and their respective programs
- Attend and participate in QIAC meetings
- Provides consultation & technical assistance to CITs and Directors
- Plan, implement and report on program or department-level QI projects
- Share successes and lessons learned with staff members
- Share QI tools learned with staff in their respective programs
- Create program/division-level reports using VMSG and identify program successes and measures/indicators in need of improvement
- With Program Director input, enter program goals, metrics, baseline stories, strategies, evidence and partners in VMSG
- Review customer satisfaction surveys for areas for improvement annually
- Annually review and provide input on the BHSJ CHA QI Plan

Role of Program Supervisors and Division Directors

- Review and provide input on the development/revision of public health measures to be used in programmatic decision-making
- Allow the QIAC to schedule meetings with you as needed
- Include QIAC updates on your staff meeting agendas
- Support the QIAC and their team members when implementing QI projects

QI Team: Agency-wide team consisting of representatives from BHSJ CHA's programs, divisions, or offices

1. QIAC: are QI Advisory Committee members; they are designated quality and performance improvement experts for each of the Department's programs.
2. Program refers to programs or divisions, or offices within BHSJ CHA

Appendix B: QI Annual Calendar

Activity	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
QI Team Reviews & Updates BHSJ CHA QI Plan									X			
QI Round Tables		X			X			X			X	
Programs Complete Customer Satisfaction Initiative	X	X			X	X	X					
Programs start new QI Projects			X	X	X	X	X	X	X			
Programs Update Goals, PH Measures, Strategies, and VMSG									X			
QIAC Reviews & Approves Programs' Goals, PH Measures & Strategies			X			X			X			X
QIAP reviews reports & archives data				X	X							

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

Program: Administrative Services	**Effective Date:** 8/24/2023
Subject: Cost Allocation Plan	**Last Updated:** 02/26/2026

Purpose: The purpose of this policy is to establish a consistent and compliant methodology for allocating costs to programs and funding sources. The Agency is committed to ensuring that all costs charged to Federal, State, and Local awards are reasonable, necessary, allowable, and properly allocated in accordance with Title 2 CFR Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, and other applicable regulations.

This policy ensures that costs are assigned to benefiting programs based on a documented cost allocation methodology that reflects a beneficial and causal relationship between the expense incurred and the program(s) served.

Policy Statement: The Branch-Hillsdale-St. Joseph Community Health Agency is committed to full compliance with Title 2 CFR Part 200, including Subpart E – Cost Principles.

The Agency incurs both direct and indirect costs in the course of operations:

- Direct costs are those that can be specifically identified with a particular program, grant, activity, or employee.
- Indirect costs are those that benefit multiple programs or activities and cannot be readily assigned to a single cost objective without disproportionate effort.

All costs, whether direct or indirect, shall be:

- Necessary and reasonable for the performance of the award
- Allowable under applicable Federal, State, and Local regulations
- Allocated based on a documented methodology that ensures equitable distribution among benefiting programs
- Treated consistently across all funding sources

Indirect costs will be accumulated in an indirect cost pool and allocated to benefiting programs using a rational and consistently applied distribution base that reflects relative benefit received. Costs treated as indirect will not be charged directly to programs, and costs charged directly will not be included in the indirect cost pool.

Reviewed Date: 11/13/2025 BOH

Unallowable costs, as defined under 2 CFR Part 200 or other applicable regulations, will be identified and excluded from any allocation to programs.

The Agency will maintain documentation supporting the methodology and calculations used in its cost allocation plan.

Scope: This policy applies to all costs incurred by the Agency, regardless of funding source.

Responsible Party: Administrative Services

Implementing Procedure:

1. **Salaries and Fringes**:
   a. Employees record actual time worked into an electronic timekeeping system. Time entries must be approved by the employee's supervisor. Salaries and related fringe benefits are allocated to programs based on actual time worked in each program during the payroll period, in accordance with 2 CFR 200.430.
   b. If an employee is on leave (sick/vacation), that time is distributed based on the other days worked during that payroll. If an employee is on leave for an entire pay period, that leave time is distributed based on the allocation from the immediately preceding payroll period.
   c. The monthly LSA expense is allocated based on the most recent budgeted Full-Time Equivalent FTE allocation in effect at the time of the charge.

2. **Supplies and Materials:**
   a. Supplies and materials that directly benefit a specific program are charged directly to that program as indicated on the purchase requisition.
   b. Shared supplies that benefit multiple programs are allocated based on documented historical usage or another reasonable and consistently applied methodology.
   c. Printing and copy expenses are allocated through the indirect cost pool unless specifically identifiable to a single program. Postage is allocated based on actual usage reports generated from the postage meters.

3. **Travel**
   a. All travel expenses are entered into the electronic timekeeping system and charged directly to the program in which the travel was incurred. Travel must comply with Agency travel policy and applicable Federal and State regulations.

4. **Communications**
   a. Communication expenses are allocated based on the current approved budgeted FTE allocation in effect at the time the expense is recorded.

5. **Space/Facility Costs**
   a. Space-related costs (e.g., rent, utilities, maintenance) are allocated based on the square footage of occupied space and the FTE(s) assigned to that space.
   b. If a room is used exclusively by one program, 100% of the associated space cost is allocated to that program.
   c. Common areas (e.g., conference rooms, break rooms, hallways) that cannot be specifically assigned to a program or FTE are included in the indirect cost pool.

6. **All Others**

a. Items/services (supplies, training expenses, etc.) that directly benefit a program are charged to that program.
b. The following costs are allocated through indirect unless specifically attributable to a single program:
    i. Miscellaneous shared supplies
    ii. Audit and legal expenses
    iii. Insurance
c. Program-support functional areas are allocated as follows:
    i. Personal Health and Disease Prevention costs are allocated based on each benefiting program's percentage of total salary and fringe within the allocation base.
    ii. Health Education and Promotion costs are allocated using the same salary/fringe percentage methodology.
    iii. Environmental Health costs are allocated using the same salary/fringe percentage methodology.
d. Any cost that cannot be directly assigned to a specific program, employee, or established allocation base will be coded to Administration and distributed through the indirect cost pool.

7. Indirect Costs

a. Indirect costs are accumulated in an indirect cost pool.
b. The indirect cost pool is distributed across all benefiting programs based on each program's percentage of total salaries and fringes benefits, which serves as the approved allocation base.
c. Costs treated as indirect will not be charged directly to programs.

8. **Reconciliation of Budget-Based Allocations**

Allocations based on budget FTE or salary spreads are reconciled to actual values twice annually.

a. March 31 (mid-year review)
b. September 30 (fiscal year-end)

Adjustments are made as necessary to ensure that final allocations reflect actual activity and comply with 2 CFR Part 200 requirements for accuracy and allowability.

Prepared By: Theresa Fisher
Approved By: Board of Health
Approval Date: 2/26/2026
Revision Number: 2026.02.26

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

Program: Administrative Services	**Effective Date:** 8/24/2023
Subject: Cost Allocation Plan	**Last Updated:**

Purpose: To allocate various costs to programs in a consistent manner based upon certain methods, detailed below.

Policy Statement: The agency incurs many different costs for operation. Some of these can be directly traced to a program or employee, sometimes they cannot. The costs that aren't directly traceable to specific programs /employees need to be allocated in a reasonable, allowable and consistent manner.

Scope: Any cost that is incurred by the agency.

Responsible Party: Administrative Services

Implementing Procedure:

1. **Salaries and Fringes**:
   a. Employees enter time into an electronic time entry system, which is then approved by their supervisor. It is allocated based on the time each associate spent working in each program. If an employee takes leave time (sick/vacation), that time is distributed based on the other days worked during that payroll. If an employee uses leave time for an entire payroll, that time is distributed based on the prior payroll's spread.
   b. *The exception to this is the LSA expense. This monthly bill is allocated based on the most recent budgeted FTE allocation that's in effect at that point in time.

2. **Supplies and Materials:**
   a. Supplies are allocated either by where they're charged on the purchase requisition (if they directly benefit the program(s) or they're based on a spread derived on past usage of those supplies/materials.
   b. Items such as printing and copy expenses are distributed through indirect.
   c. Postage is allocated based on actual usage reports generated from the postage meters.

3. **Travel**
   a. All travel is entered into the electronic entry system and is directly charged to the program in which it was incurred.

4. **Communications**

Reviewed Date: 11/13/2025 BOH

a. *Distributed based on the current budgeted FTE allocation for that point in time.

5. **Space/Facility Costs**
   a. *Allocated based on the square footage of the room and the FTE(s) who occupy it. If the room is used by only one program, the entire cost is allocated to said program. Common areas (lunchroom, conference rooms) that can't be tied to a program or FTE are distributed as indirect.

6. **All Others**
   a. Items/services (supplies, training expenses, etc.) that directly benefit a program are charged to that program.
   b. Miscellaneous supplies, audit/legal expense, and insurance costs are distributed through indirect. Prevention Services costs are allocated based on the percentage of total salary/fringe each program in the spread consists of. Health Education Service costs are allocated based on the percentage of total salary/fringe each program in the spread consists of. Environmental Health (EH) costs are allocated based on the percentage of total salary/fringe each program in the spread consists of.
   c. Any cost that can't be directly tracked to a program, associate or spread will be coded under the correct account number in administration and distributed as indirect.

7. **Indirect Costs**
   a. Distributed across all programs based on percentage of salaries/fringes in each program.

*All cost allocations for items that are based on budget spreads are brought to actual values based on actual time worked at March 31st (six months) and September 30th (year-end).

Prepared By: Theresa Fisher
Approved By: Board of Health
Approval Date: 8/24/2023
Revision Number: 2023.08.24

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
www.bhsj.org

Program: Administrative Services	**Effective Date:** 8/24/2023
Subject: Cost Allocation Plan	**Last Updated:** 02/26/2026

Purpose: ~~To allocate various costs to programs in a consistent manner based upon certain methods, detailed below.~~ The purpose of this policy is to establish a consistent and compliant methodology for allocating costs to programs and funding sources. The Agency is committed to ensuring that all costs charged to Federal, State, and Local awards are reasonable, necessary, allowable, and properly allocated in accordance with Title 2 CFR Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, and other applicable regulations.

This policy ensures that costs are assigned to benefiting programs based on a documented cost allocation methodology that reflects a beneficial and causal relationship between the expense incurred and the program(s) served.

Policy Statement: ~~The agency incurs many different costs for operation. Some of these can be directly traced to a program or employee, sometimes they cannot. The costs that aren't directly traceable to specific programs /employees need to be allocated in a reasonable, allowable and consistent manner.~~ The Branch-Hillsdale-St. Joseph Community Health Agency is committed to full compliance with Title 2 CFR Part 200, including Subpart E – Cost Principles.

The Agency incurs both direct and indirect costs in the course of operations:

- **Direct costs** are those that can be specifically identified with a particular program, grant, activity, or employee.
- **Indirect costs** are those that benefit multiple programs or activities and cannot be readily assigned to a single cost objective without disproportionate effort.

All costs, whether direct or indirect, shall be:

- Necessary and reasonable for the performance of the award
- Allowable under applicable Federal, State, and Local regulations
- Allocated based on a documented methodology that ensures equitable distribution among benefiting programs
- Treated consistently across all funding sources

Reviewed Date: 11/13/2025 BOH

Indirect costs will be accumulated in an indirect cost pool and allocated to benefiting programs using a rational and consistently applied distribution base that reflects relative benefit received. Costs treated as indirect will not be charged directly to programs, and costs charged directly will not be included in the indirect cost pool.

Unallowable costs, as defined under 2 CFR Part 200 or other applicable regulations, will be identified and excluded from any allocation to programs.

The Agency will maintain documentation supporting the methodology and calculations used in its cost allocation plan.

Scope: ~~Any cost that is incurred by the agency.~~ This policy applies to all costs incurred by the Agency, regardless of funding source.

Responsible Party: Administrative Services

Implementing Procedure:

1. **Salaries and Fringes**:
   a. Employees record actual time worked ~~enter time~~ into an electronic ~~time entry~~ timekeeping system. Time entries must be approved by the employee's ~~, which is then approved by their~~ supervisor. Salaries and related fringe benefits are allocated to programs based on actual time worked in each program during the payroll period, in accordance with 2 CFR 200.430. ~~It is allocated based on the time each associate spent working in each program.~~
   ~~a.~~b. If an employee ~~takes~~ is on leave ~~time~~ (sick/vacation), that time is distributed based on the other days worked during that payroll. If an employee is on ~~uses~~ leave ~~time~~ for an entire pay~~roll~~ period, that leave time is distributed based on the allocation from the immediately preceding payroll period. ~~prior payroll's spread.~~
   ~~b.~~c. ~~*The exception to this is the LSA expense.~~ ~~This~~ The monthly LSA expense ~~bill~~ is allocated based on the most recent budgeted Full-Time Equivalent FTE allocation ~~that's~~ in effect at ~~that point in time~~ the time of the charge.

2. **Supplies and Materials:**
   a. Supplies ~~are allocated either by where they're charged on the purchase requisition (if they directly benefit the program(s) or they're based on a spread derived on past usage of those supplies/materials.~~and materials that directly benefit a specific program are charged directly to that program as indicated on the purchase requisition.
   b. Shared supplies that benefit multiple programs are allocated based on documented historical usage or another reasonable and consistently applied methodology.
   ~~b. Items such as printing and copy expenses are distributed through indirect.~~Printing and copy expenses are allocated through the indirect cost pool unless specifically identifiable to a single program.
   c. Postage is allocated based on actual usage reports generated from the postage meters.

3. **Travel**
   a. All travel expenses are ~~is~~ entered into the electronic timekeeping~~entry~~ system and ~~is directly~~ charged directly to the program in which the travel~~it~~ was incurred. Travel must comply with Agency travel policy and applicable Federal and State regulations.

4. **Communications**

a. Communication expenses are allocated based on the ~~*Distributed based on~~ the current approved budgeted FTE allocation ~~for that point in time~~in effect at the time the expense is recorded.

5. Space/Facility Costs

a. Space-related costs (e.g., rent, utilities, maintenance) are allocated based on the square footage of occupied space and the FTE(s) assigned to that space.

b. If a room is used exclusively by one program, 100% of the associated space cost is allocated to that program.

~~a.~~c. Common areas (e.g., conference rooms, break rooms, hallways) that cannot be specifically assigned to a program or FTE are included in the indirect cost pool. ~~*Allocated based on the square footage of the room and the FTE(s) who occupy it. If the room is used by only one program, the entire cost is allocated to said program. Common areas (lunchroom, conference rooms) that can't be tied to a program or FTE are distributed as indirect.~~

6. All Others

a. Items/services (supplies, training expenses, etc.) that directly benefit a program are charged to that program.

b. The following costs are allocated through indirect unless specifically attributable to a single program:

i. Miscellaneous shared supplies

ii. Audit and legal expenses

iii. Insurance

c. Program-support functional areas are allocated as follows:

i. Personal Health and Disease Prevention costs are allocated based on each benefiting program's percentage of total salary and fringe within the allocation base.

ii. Health Education and Promotion costs are allocated using the same salary/fringe percentage methodology.

~~.~~iii. Environmental Health costs are allocated using the same salary/fringe percentage methodology.

~~b. Miscellaneous supplies, audit/legal expense, and insurance costs are distributed through indirect. Prevention Services costs are allocated based on the percentage of total salary/fringe each program in the spread consists of. Health Education Service costs are allocated based on the percentage of total salary/fringe each program in the spread consists of. Environmental Health (EH) costs are allocated based on the percentage of total salary/fringe each program in the spread consists of.~~

~~c.~~d. Any cost that ~~can't~~ cannot be directly assigned to a specific program, employee, or established allocation base will be coded to Administration and distributed through the indirect cost pool. ~~tracked to a program, associate or spread will be coded under the correct account number in administration and distributed as indirect.~~

7. Indirect Costs

a. Indirect costs are accumulated in an indirect cost pool.

b. The indirect cost pool is ~~D~~distributed across all benefiting programs based on each program's percentage of total salaries and ~~/~~fringes benefits, which serves as the approved allocation base. ~~in each program.~~

c. Costs treated as indirect will not be charged directly to programs.

8. Reconciliation of Budget-Based Allocations

Allocations based on budget FTE or salary spreads are reconciled to actual values twice annually.

a. March 31 (mid-year review)

b. September 30 (fiscal year-end)

Adjustments are made as necessary to ensure that final allocations reflect actual activity and comply with 2 CFR Part 200 requirements for accuracy and allowability.

~~*All cost allocations for items that are based on budget spreads are brought to actual values based on actual time worked at March 31st (six months) and September 30th (year-end).~~

Prepared By: Theresa Fisher
Approved By: Board of Health
Approval Date: ~~8/24/2023~~2/26/2026
Revision Number: ~~2023.08.24~~2026.02.26