ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET M-1

Check Applicable Box [ ] RHC [ ] FQHC

		COMPENSAT-ION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASSFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs								9
10	Subtotal (sum of lines 1-9)								10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11-13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies								15
16	Transportation (Health Care Staff)								16
17	Depreciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs								19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15-20)								21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)								22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23-27)								28
	FACILITY OVERHEAD								
29	Facility Costs								29
30	Administrative Costs								30
31	Total Facility Overhead (sum of lines 29 and 30)								31
32	Total facility costs (sum of lines 22, 28 and 31)								32

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET M-2
Check Applicable Box:	[ ] RHC [ ] FQHC		

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians						1
2	Physician Assistants						2
3	Nurse Practitioners						3
4	Subtotal (sum of lines 1-3)						4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
8	Total FTEs and Visits (sum of lines 4-7)						8
9	Physician Services Under Agreements						9

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10	Total costs of health care services (from Worksheet M-1, column 7, line 22)		10
11	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)		11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		13
14	Total facility overhead - (from Worksheet M-1, column 7, line 31)		14
15	Parent provider overhead allocated to facility (see instructions)		15
16	Total overhead (sum of lines 14 and 15)		16
17	Allowable GME overhead (see instructions)		17
18	Subtract line 17 from line 16		18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		20

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 14 equals "Y"), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM_____ TO_____	WORKSHEET M-3
Check Applicable Box:	[ ] RHC [ ] FQHC	[ ] Title V [ ] Title XIX [ ] Title XVIII	

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1
2	Cost of vaccines and their administration (from Worksheet M-4, line 15)		2
3	Total allowable cost excluding vaccine (line 1 minus line 2)		3
4	Total Visits (from Worksheet M-2, column 5, line 8)		4
5	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

		Calculation of Limit (1)		
		Prior to January 1	On or after January 1	
		1	2	
8	Per visit payment limit (from CMS Pub. 27,Sec. 505 or your intermediary)			8
9	Rate for Program covered visits (see instructions)			9
CALCULATION OF SETTLEMENT				
10	Program covered visits excluding mental health services (from intermediary records)			10
11	Program cost excluding costs for mental health services (line 9 x line 10)			11
12	Program covered visits for mental health services (from intermediary records)			12
13	Program covered cost from mental health services (line 9 x line 12)			13
14	Limit adjustment for mental health services (see instructions)			14
15	Graduate Medical Education Pass Through Cost (see instructions)			15
16	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *			16
17	Primary payer amounts			17
18	Less: Beneficiary deductible (from intermediary records)			18
19	Net Program cost excluding vaccines (line 16 minus sum of lines 17 and 18)			19
20	Reimbursable cost of RHC/FQHC services, excluding vaccine (80% of line 19)			20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)			21
22	Total reimbursable Program cost (line 20 plus line 21)			22
23	Reimbursable bad debts (see instructions)			23
24	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			24
25	Other adjustments (see instructions) (specify)			25
26	Net reimbursable amount (lines 22 plus 23 plus or minus line 25)			26
27	Interim payments			27
28	Tentative settlement (for fiscal intermediary use only)			28
29	Balance due component/program (line 26 minus lines 27 and 28)			29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2			30

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

* For line 15, use column 2 only for graduate medical education pass through cost.

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	PROVIDER NO.: _____ COMPONENT NO.: _____	PERIOD: FROM _____ TO: _____	WORKSHEET M-4
Check Applicable Box:	[ ] RHC [ ] FQHC	[ ] Title V [ ] Title XIX [ ] Title XVIII	

		PNEUMOCOCCAL	INFLUENZA
		1	2
1	Health care staff cost (from Worksheet M-1, column 7, line 10)		
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time		
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)		
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)		
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)		
6	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)		
7	Total overhead (from Worksheet M-2, line 16)		
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)		
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)		
10	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)		
11	Total number of pneumococcal and influenza vaccine injections (from your records)		
12	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)		
13	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries		
14	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)		
15	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		
16	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		

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ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER NO.: / COMPONENT NO.:	PERIOD FROM_____ TO_____	WORKSHEET M-5

Check Applicable Box: [ ] RHC [ ] FQHC

	DESCRIPTION			Part B 1 mm/dd/yyyy	Part B 2 Amount	
1	Total interim payments paid to providers					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE", or enter zero (1).	Program to Provider	.01			3.01
			.02			3.02
			.03			3.03
			.04			3.04
			.05			3.05
		Provider to Program	.50			3.50
			.51			3.51
			.52			3.52
			.53			3.53
			.54			3.54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 28)					4

TO BE COMPLETED BY INTERMEDIARY

5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1).	Program to Provider	.01			5.01
			.02			5.02
			.03			5.03
		Provider to Program	.50			5.50
			.51			5.51
			.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to Provider	.01			6.01
		Provider to Program	.02			6.02
7	Total Medicare liability (see instructions)					7
8	Name of Contractor		Contractor Number			8
	Signature of Authorized Person		(Month, Day, Year)			

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.