This report is required by law (42 USC. 1395g: CFR 413.20(b)). Failure to report can result in all payments made during the reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO: 0938-0107

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PART I

Intermediary Use Only:

[ ] Audited [ ] Desk Reviewed Date Received _____ Intermediary No. _____ [ ] Initial [ ] Final [ ] Re-opened

PART I - STATISTICAL DATA [ ] Projected Cost Report [ ] Actual/Final Cost Report

Check applicable box [ ] Electronic filed cost report [ ] Manually submitted cost report Date: Time:

1	Name:	1
1.01	Street: P.O. Box:	1.01
1.02	City: State: Zip Code:	1.02
1.03	County:	1.03
2	Provider Number:	2
3	Designation:	3
4	Reporting Period: From To	4

		Type of Control (see instructions)	Type of Provider (see instructions)	Date Certified	
	1	2	3	4	
5					5

		Source of Federal Funds (see instructions)	Grant Award Number (see instructions)	Date	
	1	2	3	4	
6					6

7	Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described in Instructions) and Medicare Billing Numbers (Include all Part B Billing Numbers)		7
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

8	Supervisory Physicians		8
	Name	Hours of Supervision For Reporting Period	
	1	2	
8.01			8.01
8.02			8.02
8.03			8.03
8.04			8.04
8.05			8.05

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.1)

INDEPENDENT RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO:	PERIOD: From: To:	WORKSHEET S PART I (Cont.) & PART II

PART I (CONTINUED)-STATISTICAL DATA

9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.			9
10	If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.)			10
11	Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day			11
	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07
12	Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.			12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07
13	If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for No Medicare Utilization.			13
14	Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.			14

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____ (Provider Name and Number) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Facility Title Date

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0107. The time required to complete this information collection is estimated to average 50 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

FORM CMS-222-92 (3-2010) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.2)

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER NO.: _____ CLINIC NO.: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PART III

PART III - STATISTICAL DATA FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING

1	Name:		1
2	Street:	P.O. Box:	2
3	City: State:	Zip Code:	3
4	County:		4
5	Provider Number:		5
6	Designation: Date Certified:		6

7	Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described in Instructions) and Medicare Billing Numbers (Include all Part B Billing Numbers)		7
	Name	Billing Number	
	1	2	
7.01			7.01
7.02			7.02
7.03			7.03
7.04			7.04
7.05			7.05

8	Supervisory Physicians		8
	Name	Hours of Supervision For Reporting Period	
	1	2	
8.01			8.01
8.02			8.02
8.03			8.03
8.04			8.04
8.05			8.05

9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.		9
10	If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.)		10
11	Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day		11

	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07

12	Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.			12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07

FORM CMS-222-92 (1-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903.2)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES | Facility No. | Reporting Period From To | WORKSHEET A Page 1

		COST CENTER	Compen-sation	Other	Total (Col. 1 + 2)	Reclassi-fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
			1	2	3	4	5	6	7	
		FACILITY HEALTH CARE STAFF COSTS								
1	0100	Physician								1
2	0200	Physician Assistant								2
3	0300	Nurse Practitioner								3
4	0400	Visiting Nurse								4
5	0500	Other Nurse								5
6	0600	Clinical Psychologist								6
7	0700	Clinical Social Worker								7
8	0800	Laboratory Technician								8
9	0900	Other (Specify)								9
10	1000									10
11	1100									11
12		Subtotal-Facility Health Care Staff Costs								12
		COSTS UNDER AGREEMENT								
13	1300	Physician Services Under Agreement								13
14	1400	Physician Supervision Under Agreement								14
15	1500									15
16		Subtotal Under Agreement (Lines 13-15)								16
		OTHER HEALTH CARE COSTS								
17	1700	Medical Supplies								17
18	1800	Transportation (Health Care Staff)								18
19	1900	Depreciation-Medical Equipment								19
20	2000	Professional Liability Insurance								20
21	2100	Other (Specify)								21
22	2200									22
23	2300									23
24		Subtotal-Other Health Care Costs (Lines 17-23)								24
25		Total Cost of Services (Other Than Overhead And Other RHC/FQHC Services) Sum of Lines 12, 16, And 24								25
		FACILITY OVERHEAD-FACILITY COST								
26	2600	Rent								26
27	2700	Insurance								27
28	2800	Interest On Mortgage Or Loans								28
29	2900	Utilities								29

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No.	Reporting Period From To	WORKSHEET A Page 2

		COST CENTER	Compen-sation	Other	Total (Col. 1 + 2)	Reclassi-fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)
			1	2	3	4	5	6	7
30	3000	Depreciation-Buildings And Fixtures							
31	3100	Depreciation-Equipment							
32	3200	Housekeeping And Maintenance							
33	3300	Property Tax							
34	3400	Other(Specify)							
35	3500								
36	3600								
37		Subtotal-Facility Costs (Lines 26-36)							
		FACILITY OVERHEAD-ADMINISTRATIVE COSTS							
38	3800	Office Salaries							
39	3900	Depreciation-Office Equipment							
40	4000	Office Supplies							
41	4100	Legal							
42	4200	Accounting							
43	4300	Insurance							
44	4400	Telephone							
45	4500	Fringe Benefits And Payroll Taxes							
46	4600	Other (Specify)							
47	4700								
48	4800								
49		Subtotal-Administrative Cost (Lines 38-48)							
50		Total Overhead (Lines 37 And 49)							
		COST OTHER THAN RHC/FQHC SERVICES							
51	5100	Pharmacy							
52	5200	Dental							
53	5300	Optometry							
54	5400	Other (Specify)							
55	5500								
56	5600								
57		Subtotal-Cost Other Than RHC/FQHC (Lines 51-56)							
		NON-REIMBURSABLE COSTS (Specify)							
58	5800								
59	5900								
60	6000								
61		Subtotal Non-Reimbursable Costs (Lines 58-60)							
62		TOTAL COSTS (Sum Of Lines 25, 50, 57, And 61)				-0-			

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RECLASSIFICATIONS | Facility No. | Reporting Period From To | WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE (1)	INCREASE COST CENTER	INCREASE LINE NO.	INCREASE AMOUNT (2)	DECREASE COST CENTER	DECREASE LINE NO.	DECREASE AMOUNT (2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
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34									34
35									35
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)								36

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

(2) Transfer to Worksheet A, Col 4, line as appropriate.

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2905)

ADJUSTMENTS TO EXPENSES	Facility No.		Reporting Period From To	WORKSHEET A-2
Description (1)	Basis for Adjust-ment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added: Cost Center	Line No.
	1	2	3	4
1 Investment income on commingled restricted and unrestricted funds (chapter 2)				
2 Trade, quantity and time discounts on purchases (chapter 8)	B			
3 Rebates and refunds of expenses (chapter 8)	B			
4 Rental of building or office space to others				
5 Home office costs (chapter 21)				
6 Adjustment resulting from transactions with related organizations (chapter 10)	From Supp. Wkst. A-2-1			
7 Vending machines				
8 Practitioner Assigned by National Health Service Corps				
9 Depreciation - Buildings and Fixtures			Depreciation	30
10 Depreciation - Equipment			Depreciation	31
11 Other (Specify)				
12 Total				62

(1) Description - all line references in this column pertain to CMS Pub. PRM 15-I.

(2) Basis for adjustment (SEE INSTRUCTIONS)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-II, SECTION 2906)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Facility No.	Reporting Period From To	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I-III

Part I. Introduction. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?

[ ] Yes [ ] No (If "Yes", complete Parts II and III)

Part II. Costs incurred and adjustments required (as result of transactions with related organizations):

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL.4 MINUS COL. 5)	
Line No.	Cost Center	Expense Items	AMOUNT			
1	2	3	4	5	6	
1						1
2						2
3						3
4						4
5	TOTALS (sum of lines 1-4) Transfer col. 6, line 1-4 to Wkst. A,col.6 as appropriate) (Transfer col.6, line 5 to Wkst. A-2, col.2, line 6, Adjustment to Expenses)					5

Part III. Interrelationship of facility to related organization (s):

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires the provider to furnish the information requested on Part III of this worksheet.

This information is used by the Centers for Medicare & Medicaid Services and its intermediaries in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control, represent reasonable costs as determined under section 1861 of the Social Security Act. If the provider does not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				RELATED ORGANIZATION (S)			
SYMBOL (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
1	2	3	4	5	6	
1							1
2							2
3							3
4							4

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the provider;

B. Corporation, partnership, or other organization has financial interest in the provider;

C. Provider has financial interest in corporation, partnership, or other organization(s);

D. Director, officer, administrator, or key person of the provider or relative of such person has financial interest in related organization;

E. Individual is director, officer, administrator, or key person of the provider and related organization;

F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the provider;

G. Other (financial or non-financial) specify _____

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	Facility No.		Reporting Period From To		WORKSHEET B PARTS I & II
PART I - VISITS AND PRODUCTIVITY	Part A - Visits And Productivity				
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits	Productivity Standard	Minimum Visits (Col. 1 x Col. 3)	Greater of Col. 2 or Col. 4
1. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Subtotal (Sum of lines 1-3)					
5. Visiting Nurse					
6. Clinical Psychologist					
7. Clinical Social Worker					
8. Total Staff					
9. Physician Services Under Agreement					

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES	
	Amount
10. Cost of RHC/FQHC Services - excluding overhead - (W/S A,Col. 7, Line 25)	
11. Cost of Other Than RHC/FQHC Services - Excluding overhead (W/S A, Col. 7, Sum of Lines 57 and 61)	
12. Cost of All Services - excluding overhead - (Sum of Lines 10 and 11)	
13. Ratio of RHC/FQHC Services (Line 10 Divided by Line 12)	
14. Total Overhead - (W/S A, Col. 7, Line 50)	
15. Overhead Applicable to RHC/FQHC Services (Line 13 x Line 14)	
16. Total Allowable Cost of RHC/FQHC Services (Sum of Lines 10 and 15)	

FORM CMS-222-92 (1-2005) INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTIONS 2907 THRU 2907.2)

DETERMINATION OF MEDICARE PAYMENT	Facility No.	Reporting Period From To	WORKSHEET C PART 1

	PART I- DETERMINATION OF RATE FOR RHC/FQHC SERVICES	AMOUNT	
1	Total Allowable Costs(Worksheet B, Part II, Line 16)		1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supplemental Worksheet B-1, Line 15)		2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (Line 1 - Line 2)		3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part 1, Column 5, Line 8		4
5	Physicians Visits Under Agreements (Worksheet B, Part 1, Column 5, Line 9)		5
6	Total Adjusted Visits (Line 4 + Line 5)		6
7	Adjusted Cost Per Visit (Line 3 divided by Line 6)		7

		1	2	2.01	3	
		Rate Period 1	Rate Period 2	Rate Period 3		
8	Maximum Rate Per Visit (See Instructions)					8
9	Rate For Medicare Covered Visits (Lessor of Line 7 or Line 8)					9

DETERMINATION OF MEDICARE PAYMENT		Facility No.	Reporting Period From To		WORKSHEET C PART II	
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	2.01	3	
		Rate period 1	Rate Period 2	Rate Period 3		
10	Rate for Medicare Covered Visits (Part I, Line 9)					10
11	Medicare Covered Visits Excluding Mental Health Services (From Intermediary Records)					11
12	Medicare Cost Excluding Costs for Mental Health Services (Line 10 multiplied by Line 11)					12
13	Medicare Covered Visits for Mental Health Services (From Intermediary Records)					13
14	Medicare Covered Cost for Mental Health Services (Line 10 multiplied by Line 13)					14
15	Limit Adjustment (Line 14 times the applicable percentage) (see instructions)					15
16	Total Medicare Cost (Line 12 plus line 15)					16
17	Less: Beneficiary Deductible (From Intermediary Records)					17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 16 minus line 17)					18
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (80% multiplied by line 18, Column 3)					19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supp. Worksheet B-1, Line 16)					20
21	Total Reimbursable Medicare Cost (Line 19 plus Line 20)					21
22	Less Payments to RHC/FQHC During Reporting Period					22
23	Balance Due To/From The Medicare Program Exclusive of Bad Debts (Line 21 less Line 22)					23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (From Provider Records)					24
24.01	Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries (From Provider Records)					24.01
25	Total Amount Due To/From The Medicare Program (Line 23 plus Line 24)					25

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Facility No.	Reporting Period From To
	1	2	2.01
PART 1 - CALCULATION OF COST	PNEUMOCOCCAL	SEASONAL INFLUENZA	H1N1
1 Health Care Staff Cost (Worksheet A, Column 7, Line 12)			
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 (Sum of Lines 3 & 4)			
6 Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25)			
7 Total Facility Overhead (Worksheet A, Column 7, Line 50)			
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 & 9)			
11 Total Number of Pneumococcal and Influenza Vaccine Injections (From Provider Records)			
12 Cost Per Pneumococcal and Influenza Vaccine Injection (Line 10 divided by Line 11)			
13 Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries			
14 Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 12 Multiplied by Line 13)			
15 Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 10, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part I, Line 2			
16 Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 14, Columns 1, 2, 2.01, and 2.02) Transfer to Wkst. C, Part II, Line 20			

SUPPLEMENTAL WORKSHEET B-1	
2.02	
INFLUENZA & H1N1 (See instructions)	
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