

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 CCN :	PERIOD: FROM: TO:	WORKSHEET S PART I
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Intermediary Use Only:

Audited

Desk Reviewed

Date Received _____

Contractor No. _____

Initial

Re-opened

Final

PART I - STATISTICAL DATA

Projected Cost Report

Actual/Final Cost Report

Check applicable box	<input type="checkbox"/> Electronic filed cost report	Date:
	<input type="checkbox"/> Manually submitted cost report	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	CCN :				2
3	Designation:				3
4	Reporting Period: From	To			4
	Type of Control (see instructions)		Type of Provider (see instructions)	Date Certified	
5	1	2	3	4	5

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

8.50	Are you claiming allowable GME costs as a result of "substantial payment" for interns and residents? If yes, enter the number of Medicare visits performed by interns and residents in col. 2 and total visits in col. 3 performed by interns and residents and complete Worksheet A, lines 20.50 and 53.50 as applicable.	Y/N	XVIII	TOTAL	8.50
		1	2	3	
8.51	Have you received an approval for an exception to the productivity standard?				8.51

INDEPENDENT RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT PART I (CONT.) - STATISTICAL DATA	PROVIDER CCN :	PERIOD: FROM: TO:	WORKSHEET S PART I (Cont.) & PART II
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9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.			9
10	If line 9 is "Y", specify <i>type</i> 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 <i>n</i> o Medicare <i>u</i> tilization.			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 WERE 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 certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name and Number) for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete, and prepared from the books and records of the Provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the 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: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

FORM CMS-222-92 (05-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 2903 and 2903.2)

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	PROVIDER CCN: CLINIC CCN:	PERIOD: FROM: TO:	WORKSHEET S PART III
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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:
4	County:		
5	Provider Number:		
6	Designation:	Date Certified:	

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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL
BALANCE OF EXPENSES

PROVIDER *CCN*:

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
20.50	2050	<i>Allowable GME Pass Through Costs</i>							<i>20.50</i>
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

FORM CMS-222-92 (05-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 2904)

RECLASSIFICATIONS		PROVIDER CCN:		PERIOD: FROM: TO:		WORKSHEET A-1		
EXPLANATION OF ENTRY	CODE	INCREASE			DECREASE			
	(1)	COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	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
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
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. 15-2, SECTION 2905)

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	PROVIDER <i>CCN</i> :	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 (1)	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					
7.01. Medical Nutrition Therapist (FQHC only)					
7.02. Diabetes Self Management Training (FQHC only)					
8. Total Staff					
9. Physician Services Under Agreement					

(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted (Wkst. S, line 8.51 equals "Y"), input in col. 3, lines 1 through 3, the productivity standards derived by the contractor.

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

	Amount
10. Cost of RHC/FQHC Services - excluding overhead - (Wkst. A, col. 7, line 25 <i>minus wkst. A, col. 7, line 20.5</i>)	
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 - (<i>Wkst. A, col. 7, line 50</i>)	
<i>14.01. Allowable GME Overhead (See instructions)</i>	
<i>14.02. Net Facility Overhead Costs</i>	
15. Overhead Applicable to RHC/FQHC Services (<i>See instructions</i>)	
16. Total Allowable Cost of RHC/FQHC Services (sum of lines 10 and 15)	

DETERMINATION OF MEDICARE PAYMENT		PROVIDER CCN:	PERIOD: FROM: TO:		WORKSHEET C PART I
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
8	Maximum Rate Per Visit (See Instructions)	1	2	2.01	3
		Rate Period 1	Rate Period 2	Rate Period 3	
9	Rate For Medicare Covered Visits (Lessor of Line 7 or Line 8)				9

FORM CMS-222-93 (08-2004) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 2908 AND 2908.1)

DETERMINATION OF MEDICARE PAYMENT		PROVIDER CCN:	PERIOD: FROM: TO:		WORKSHEET C PART II
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	2.01	3
10	Rate for Medicare Covered Visits (Part I, Line 9)	Rate period 1	Rate Period 2	Rate Period 3	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
15.10	<i>Graduate Medical Education Pass Through Cost (see instructions)</i>				15.10
16	Total Medicare Cost (Line 12 plus line 15 <i>plus line 15.10</i>)				16
17	Less: Beneficiary Deductible for RHC only (see instructions) (From contractor records)				17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (see instructions)				18
18.01	Total Medicare charges (see instructions)(from contractor's records (PS&R Report))				18.01
18.02	Total Medicare preventive charges (see instructions)(from provider's records)				18.02
18.03	Total Medicare preventive costs ((line 18.02/line 18.01) times line 16)				18.03
18.04	Total Medicare non-preventive costs ((line 18 minus line 18.03) times 80%)				18.04
18.05	Net Medicare cost (see instructions)				18.05
18.06	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)				18.06
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (see instructions)				19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supp. Worksheet B-1, line 16)				20
20.50	<i>Other adjustments (specify)</i>				20.50
21	Total Reimbursable Medicare Cost (see instructions)				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
24.02	Tentative settlement (for contractor use only)				24.02
24.10	<i>Adjusted reimbursable bad debts (see instructions)</i>				24.10
24.11	<i>Sequestration adjustment (see instructions)</i>				24.11
25	Total Amount Due To/From The Medicare Program (<i>see instructions</i>)				25

FORM CMS-222-92 (05-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTIONS 2908 AND 2908.2)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I-III
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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.

SYMBOL (1)	Name	Percentage of Ownership	RELATED ORGANIZATION (S)		
			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 _____

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET B-1	
		1	2	2.01	2.02
PART 1 - CALCULATION OF COST		PNEUMOCOCCAL	SEASONAL INFLUENZA	H1N1	INFLUENZA & H1N1 (See instructions)
1	Health Care Staff Cost (Worksheet A, Column 7, Line 12)				1
2	Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time				2
3	Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2)				3
4	Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records)				4
5	Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4)				5
6	Total Direct Cost of the Facility (Worksheet A, Column 7, Line 25)				6
7	Total Facility Overhead (Worksheet A, Column 7, Line 50)				7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6)				8
9	Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8)				9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 9)				10
11	Total Number of Pneumococcal and Influenza Vaccine Injections (From Provider Records)				11
12	Cost Per Pneumococcal and Influenza Vaccine Injection (Line 10 divided by Line 11)				12
13	Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries				13
14	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 12 Multiplied by Line 13)				14
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				15
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				16