

CHAPTER 44
 FEDERALLY QUALIFIED HEALTH CENTER COST REPORT
 CMS-224-14
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4400. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §§1815(a) and 1861(v)(1)(A) of the Social Security Act (the Act), providers of medical and other health services as defined under §1861(s), participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Federally qualified health centers (FQHCs) are required under 42 CFR 405.2470, to maintain adequate financial and statistical records and provide annual cost reports as the Secretary determines necessary to administer the program. The data submitted on the cost reports supports management of Federal programs. The information reported on Form CMS-224-14, must conform to the requirements and principles set forth in the Provider Reimbursement Manual, (CMS Pub. 15), as well as those set forth in the Medicare

Benefit Policy Manual, CMS Pub. 100-02, chapter 13, and the Medicare Claims Processing Manual, CMS Pub. 100-04, chapter 9.

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added §1834(o) of the Act to establish a new system of payment for the costs of FQHC services under Medicare Part B based on prospectively set rates. The statute requires implementation of the FQHC prospective payment system (FQHC PPS) for FQHCs with cost reporting periods beginning on or after October 1, 2014. Form CMS-224-14 must be used by all freestanding FQHCs for cost reporting periods beginning on or after October 1, 2014. The FQHC cost report must be submitted to the Medicare administrative contractor (MAC) (hereafter referred to as contractor) electronically in accordance with 42 CFR 413.24(f)(4). Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period, in accordance with 42 CFR 413.24(f)(2).

NOTE: This form is to be used by freestanding FQHCs and FQHC's previously reported as part of a SNF complex or HHA complex. FQHCs that are part of a hospital healthcare complex~~hospital-based~~ must use the Form CMS-2552.

The public reporting and recordkeeping burden for this cost report is estimated to average 58 hours per response. This includes time for reviewing instructions, gathering data, maintaining records, and completing the forms. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Centers for Medicare and Medicaid Services

PRA Reports Clearance Officer

7500 Security Boulevard

Mail Stop C4-26-05

Baltimore, Md. 21244-1850

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4400.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. Use the following rounding standards for such computations:

1. Round to 2 decimal places:
 - a. Rates
 - b. Cost per visit
 - c. Cost for pneumococcal and influenza vaccines

2. Round to 6 decimal places:
 - a. Ratios
 - b. Unit cost multiplier

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost allocated. This residual is adjusted to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount allocated.

4401. ACRONYMS AND ABBREVIATIONS

Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

- | | | |
|---------|---|----------------------------|
| A&G | - | Administrative and General |
| CAP REL | - | Capital-Related |

CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number (formerly known as provider number)
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare & Medicaid Services
ECR	-	Electronic Cost Report
FQHC	-	Federally Qualified Health Center
HCRIS	-	Healthcare Cost Report Information System
HRSA	-	Health Resources and Services Administration
I&R	-	Interns and Residents
MAC	-	Medicare Administrative Contractor
NPR	-	Notice of Program Reimbursement
PCRE	-	Primary Care Residency Expansion
PS&R Report	-	Provider Statistical and Reimbursement Report
RCE	-	Reasonable Compensation Equivalency Limit
THC	-	Teaching Health Center

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FORM CMS-224-14

4402

4402. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-224-14

Step

No.

Worksheet

Instructions

1	S, Parts I & II	Read §§4404.1 and 4404.2. Complete Parts I and II.
2	S-1, Part I	Read §4405.1. Complete entire worksheet.
3	S-1, Part II	Read §4405.2. Complete entire worksheet.
4	S-2	Read §4406. Complete entire worksheet if applicable.
5	S-3, Part I	Read §4407.1. Complete entire worksheet.
6	S-3, Part II	Read §4407.2. Complete entire worksheet.
7	S-3, Part III	Read §4407.3. Complete entire worksheet.
8	A	Read §4408. Complete columns 1 through 3.
9	A-1	Read §4409. Complete entire worksheet if applicable.
10	A	Read §4408. Complete columns 4 and 5.
11	A-2-1, Parts I & II	Read §4411.1 and 4411.2. Complete entire worksheet if applicable.
12	A-2	Read §4410. Complete entire worksheet.
13	A	Read §4408. Complete columns 6 and 7.
14	B, Parts I & II	Read §§4412.1 and 4412.2. Complete entire worksheet.

- | | | |
|----|-------------|---|
| 15 | B-1 | Read §4413. Complete entire worksheet. |
| 16 | E | Read §4414. Complete lines 1 - 17. |
| 17 | E-1 | Read §4415. Complete entire worksheet. |
| 18 | E | Read §4414. Complete lines 18 - 21 as applicable. |
| 19 | F-1 | Read §4416. Complete entire worksheet. |
| 20 | S, Part III | Read §4404.3. Complete Part III. |

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4403. SEQUENCE OF ASSEMBLY

The following list of assembly of worksheets is provided so all FQHCs are consistent in the order of submission of their annual cost report. All FQHCs using Form CMS-214-14 are to adhere to this sequence. Where worksheets are not completed because they are not applicable, blank worksheets are not included in the assembly of the cost report.

Worksheet

Part

S

I, II & III

S-1	I & II
S-2	
S-3	I, II & III
A	
A-1	
A-2	
A-2-1	I & II
B	I & II
B-1	
E	
E-1	
F-1	

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FORM CMS-224-14

4404.1

4404. WORKSHEET S - FEDERALLY QUALIFIED HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4404.1 Part I - Cost Report Status.--This section is to be completed by the FQHC and contractor as indicated on the worksheet. If this is a consolidated cost report, the organization must choose a primary FQHC whose CMS certification number (CCN) must be utilized throughout the entire cost report.

Line 1.--Indicate if the cost report is an electronic submission by entering “Y” for yes or “N” for no in column 1. If yes, enter the electronic file creation date and time in columns 2 and 3, respectively. If no, line 2 must be completed.

Line 2.--If line 1 is no, indicate if this cost report is a manual submission by entering “Y” for yes or “N” for no. This line is only completed by FQHCs filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter 1, §110 or FQHCs demonstrating financial hardship in accordance with CMS Pub. 15-2, chapter 1, §133.

Line 3.--If this is an amended cost report, enter the number of times the cost report has been amended.

Line 4.--Enter an “F” if this is full cost report, an “L” if this is a low Medicare utilization cost report, or an “N” if this is a no Medicare utilization cost report (“L” and “N” requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110).

Lines 5 through 12 are for contractor use only:

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6.--Enter the date (mm/dd/yyyy) the accepted cost report was received from the FQHC.

Line 7.--Enter the 5 position contractor number.

Lines 8 and 9.--If this is an initial cost report enter "Y" for yes in the box on line 8. If this is a final cost report enter "Y" for yes in the box on line 9; if neither, enter "N". An initial report is the very first cost report for a particular FQHC CCN. A final cost report is a terminating cost report for a particular FQHC CCN.

Line 10.--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3 or 4.

Line 11.--Enter the software vendor code of the cost report software used by the contractor to process this HCRIS cost report file; use "4" for HFS or "3" for KPMG.

Line 12.--Complete this line only if the cost report status code on line 5 is "4". If this is a reopened cost report (response to line 5 cost report status, is "4"), enter the number of times the cost report has been reopened.

4404.2 Part II - Certification.--This certification is read, prepared, and signed by an officer or administrator of the FQHC after the cost report has been completed in its entirety

4404.3 Part III - Settlement Summary.--Enter the balance due to or due from the Medicare program. Transfer the amount from Worksheet E, line 20.

4405. WORKSHEET S-1 - FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Federally Qualified Health Center Identification Data

Part II - Federally Qualified Health Center Consolidated Cost Report Participant Identification Data

4405.1 Part I - Federally Qualified Health Center Identification Data.--The information required on this worksheet is needed to properly identify the FQHC, or in the case of a consolidated cost report, the primary FQHC. In the case of a consolidated cost report, only the primary FQHC completes the entire Worksheet S-1, Part I. All other FQHCs filing under a consolidated cost report must be listed on line 14 and its subsidiaries and must complete a separate Worksheet S-1, Part II.

Line 1, columns 1 through 4.--Enter in the appropriate column the site name, CCN, core based statistical area (CBSA) code (rural CBSA codes are assembled by placing the digits “999” in front of the two digit state code, e.g., for the state of Maryland the rural CBSA code is 99921), and certification date.

Line 1, column 5.--Indicate the type of control under which the FQHC operates by entering a number from the list below:

- | | |
|--------------------------------------|---------------------------|
| 1 = Voluntary Nonprofit, Corporation | 7 = Governmental, Federal |
| 2 = Voluntary Nonprofit, Other | 8 = Governmental, State |
| 3 = Proprietary, Individual | 9 = Governmental, County |
| 4 = Proprietary, Corporation | 10 = Governmental, City |
| 5 = Proprietary, Partnership | 11 = Governmental, Other |
| 6 = Proprietary, Other | |

Line 2.--Enter the FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2 for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4.--Enter the inclusive dates covered by this cost report. Enter in column 1, the cost report beginning date and enter in column 2, the cost report ending date.

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4405.1 (Cont.)

Line 5.--Indicate whether this FQHC is owned, leased or controlled by an entity that operates multiple FQHCs. Enter a "Y" for yes or an "N" for no. If yes, complete lines 6 through 8. Otherwise, skip to line 9.

Lines 6 through 8.--Enter the name of the entity that owns, leases or controls the FQHC, the street address, post office box (if applicable), Health Resources Services Administration (HRSA) grant award number assigned to the organization, city, state, and ZIP code.

Lines 9.--Indicate if this FQHC is part of a chain organization as defined in CMS Pub. 15-1, chapter 21, §2150 that claimed home office costs in a home office cost statement. Enter "Y" for yes or "N" for no. If yes, complete lines 10 through 12. Otherwise, skip to line 13.

Lines 10 through 12.--Enter the name of the chain organization, the street address, post office box (if applicable), the home office CCN, city, state, and ZIP code.

Line 13.--Indicate whether this FQHC is filing a consolidated cost report under CMS Pub. 100-04, chapter 9, §30.8. Enter "Y" for yes or "N" for no, **in column 1**. If yes, enter in column 2 the date the FQHC requested approval to file a consolidated cost report, in column 3 the date the contractor approved the FQHCs request to file a consolidated cost report, **and in column 4 the number of FQHCs included in this consolidated cost report other than the primary FQHC.**

Line 14.--If the response to line 13 is yes, list on line 14 and its subscripts, each FQHC that is part of this consolidated cost report, excluding the FQHC listed on line 1. Enter in column 1 the site name, column 2 the CCN, column 3 the CBSA, column 4 the date the FQHC requested approval to file as part of a consolidated cost report, and column 5 the date the contractor approved the FQHCs request to file as part of a consolidated cost report. Each FQHC listed on line 14 and its subscripts must complete a separate Worksheet S-1, Part II.

Line 15.--There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs. Indicate in column 1, the type of organization this FQHC is by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha character (s) associated with the response in column 2. For example if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D." An organization receiving a grant under §330 of the Public Health Service (PHS) Act or an outpatient health program/facility can operate as any or all of the subcategories listed under the respective numeric options presented below.

- 1) An organization receiving a grant(s) under §330 of the PHS Act:
 - A) Community Health Centers
 - B) Migrant and Seasonal Agricultural Workers Health Centers
 - C) Health Care for the Homeless Health Centers
 - D) Health Centers for Residents of Public Housing
- 2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or

- 3) Outpatient health program/facility operated by:
 - A) A tribe or tribal organization under the Indian Self-Determination Act

- B) An urban Indian organization under title V of the Indian Health Care Improvement Act
- C) Other

Line 16.--Indicate if your FQHC received a grant under §330 of the PHS Act during this cost reporting period. If this is a consolidated cost report, did the primary FQHC reported on line 1, column 2 receive a grant under §330 of the PHS Act during this cost reporting period? Enter “Y” for yes or “N” for no.

Line 17.--If the response to line 16 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

- 1 = Community Health Center (§330(e), PHS Act)
- 2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
- 3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)
- 4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)
- 5 = Other

Line 18.--Indicate if your FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the Federal Tort Claims Act (FTCA). Enter “Y” for yes or “N” for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 19.--Indicate if your FQHC is legally required to carry malpractice coverage. Enter “Y for yes or “No” for no. Malpractice insurance premiums are money paid by the FQHC to a commercial insurer to protect the FQHC against potential negligence claims made by their patients/clients.

Line 20.--If line 19 is yes, indicate if your malpractice insurance is a claims-made or occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a “claims-made” contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. Enter 1 if the malpractice insurance is a claims-made policy. Enter 2 if the malpractice insurance is an occurrence policy.

Line 21.--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.

Malpractice paid losses is money paid by the FQHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the FQHC where the FQHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often FQHCs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage the FQHC needs but could not obtain economically through the mainstream insurance market.

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4405.2

Line 22.--Indicate if malpractice premiums paid, paid losses, or self-insurance are reported in a cost center other than the Administrative and General (A&G) cost center. Enter “Y” for yes or “N” for no. If yes, submit a supporting schedule listing cost centers and amounts.

Line 23.--Is this FQHC involved in training residents in an approved graduate medical education (GME) program in accordance with 42 CFR 405.2468(f)? Enter “Y” for yes or “N” for no.

Line 24.--Is this FQHC involved in training residents in an unapproved GME program? Enter “Y” for yes or “N” for no.

Line 25.--Indicate if the FQHC received a Primary Care Residency Expansion (PCRE) grant from HRSA to train new residents in primary care residency programs. Enter “Y” for yes or “N” for no in column 1. If yes, enter the number of primary care full time equivalent (FTE) residents your FQHC trained using PCRE grant funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

Line 26.--Indicate if the FQHC received a Teaching Health Center (THC) development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter “Y” for yes or “N” for no in column 1. If yes, enter the number of FTE residents your FQHC trained using THC funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

Line 27.--Indicate if you own or lease the building or office space occupied by your FQHC. Enter a "1" for owned or a "2" for leased in column 1. If you lease the office space, enter the rent/lease expense for this cost reporting period in column 2.

4405.2 Part II - Federally Qualified Health Center Consolidated Cost Report Participant Identification Data.--Each FQHC that is included on Worksheet S-1, Part I, line 14, and applicable subscripts, who is filing as part of a consolidated cost report must complete a separate Worksheet S-1, Part II in the identical sequence that the consolidated FQHCs are reported on Worksheet S-1, Part I, line 14 and its subscripts. Do not complete this worksheet for the primary FQHC reported on Worksheet S-1, Part I, line 1.

Line 1.--Enter the FQHC site name in column 1 and the FQHC certification date in column 2. Indicate the type of control under which the FQHC operates by entering a number from the list below in column 3.

- | | |
|--------------------------------------|---------------------------|
| 1 = Voluntary Nonprofit, Corporation | 7 = Governmental, Federal |
| 2 = Voluntary Nonprofit, Other | 8 = Governmental, State |
| 3 = Proprietary, Individual | 9 = Governmental, County |
| 4 = Proprietary, Corporation | 10 = Governmental, City |
| 5 = Proprietary, Partnership | 11 = Governmental, Other |
| 6 = Proprietary, Other | |

Enter the date the FQHC terminated its participation in the Medicare program (if applicable) in column 4. In column 5, enter a "V" for a voluntary termination or an "I" for an involuntary termination.

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4405.2 (Cont.)

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If the FQHC changed ownership immediately prior to the beginning of the cost reporting period enter the date of the change of ownership in column 6. Also submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Enter the FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation (“U” for urban or “R” for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2 for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4.--There are 3 types of organizations that are eligible to enroll in Medicare as an FQHC. Indicate in column 1, the type of FQHC organization by entering a number from the list below. If your response in column 1 is “1” or “3”, enter any or all of the alpha characters associated with the response in column 2. For example if you entered “1” in column 1, enter in column 2, “A”, “B”, “C” and/or “D”. An organization receiving a grant under §330 of the PHS Act or an outpatient health program/facility can operate as any or all of the subcategories listed under the respective numeric options below.

- 1) An organization receiving a grant(s) under §330 of the PHS Act:
 - A) Community Health Centers
 - B) Migrant and Seasonal Agricultural Workers Health Centers
 - C) Health Care for the Homeless Health Centers
 - D) Health Centers for Residents of Public Housing
- 2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of “Health Center” under §330 of the PHS Act, but not receiving grant funding under §330; or
- 3) Outpatient health program/facility operated by:
 - A) A tribe or tribal organization under the Indian Self-Determination Act
 - B) An urban Indian organization under title V of the Indian Health Care Improvement Act
 - C) Other

Line 5.--Indicate if your FQHC received a grant under §330 of the PHS Act during this cost reporting period? Enter “Y” for yes or “N” for no.

Line 6.--If the response to line 5 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)

2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)

3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)

4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)

5 = Other

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4405.2 (Cont.)

Line 7.--Indicate if your FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the FTCA. Enter “Y” for yes or “N” for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 8.--Indicate if your FQHC is legally required to carry malpractice coverage. Enter “Y” for yes or “N” for no. Malpractice insurance premiums are money paid by the FQHC to a commercial insurer to protect the FQHC against potential negligence claims made by their patients/clients.

Line 9.--If line 8 is yes, indicate if your malpractice insurance is a claims-made or occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a “claims-made” contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. Enter 1 if the malpractice insurance is a claims-made policy. Enter 2 if the malpractice insurance is an occurrence policy.

Line 10.--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.

Malpractice paid losses is money paid by the FQHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the FQHC where the FQHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often FQHCs will manage their own funds or purchase a

policy referred to as captive insurance, which provides insurance coverage the FQHC needs but could not obtain economically through the mainstream insurance market.

Line 11.--Is this FQHC involved in training residents in an approved GME program in accordance with 42 CFR 405.2468(f)? Enter "Y" for yes or "N" for no.

Line 12.--Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.

Line 13.--Indicate if the FQHC received PCRE grant funding from HRSA to train new residents in primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of primary care FTE residents your FQHC trained using PCRE grant funding, and enter in column 3 the total number of visits performed by such residents during this cost reporting period.

Line 14.--Indicate if the FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents your FQHC trained using THC funding and enter in column 3 the total number of visits performed by such residents during this cost reporting period.

Line 15.--Indicate whether you own or lease the building or office space occupied by your FQHC. Enter a "1" for owned or a "2" for leased in column 1. If you lease the office space, enter the rent/lease expense for this cost reporting period in column 2.

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4406. WORKSHEET S-2 - FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT QUESTIONNAIRE

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the FQHC to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the electronic cost report (ECR). The contractor has the right

under §§1815(a) and 1883(e) of the Act to request any missing documentation. When filing a consolidated cost report, this worksheet applies only to the primary FQHC.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are “yes” or “no” unless otherwise indicated. When the instructions require documentation, indicate on the documentation the Worksheet S-2 line number the documentation supports. Lines 1 through 19 are required to be completed by all FQHCs reported on Worksheet S-1, Part I, line 1.

Line 1.--Indicate whether the FQHC has changed ownership immediately prior to the beginning of the cost reporting period. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the FQHC has terminated participation in the Medicare program. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, enter the date of termination in column 2, and “V” for voluntary or “I” for involuntary in column 3.

Line 3.--Indicate whether the FQHC is involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the FQHC or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter “Y” for yes or “N” for no in column 1. If column 1 is “Y”, submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See Pub. 15-1, chapter 10 and 42 CFR 413.17.)

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Line 4.--Indicate in column 1 whether the financial statements were prepared by a certified public accountant; enter "Y" for yes or "N" for no. If column 1 is yes, indicate the type of financial statements in column 2 by entering "A" for audited, "C" for compiled, or "R" for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3.

If column 1 is no, submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether Intern-Resident costs were claimed on the current cost report. Enter "Y" for yes or "N" for no in column 1.

Line 6.--Indicate whether Intern-Resident program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR 413.79(l) for the definition of a new program.)

Line 7.--Indicate whether graduate medical education costs were directly assigned to cost centers other than the "Allowable GME Costs" on Worksheet A, line 47. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a listing of the cost centers and amounts with the cost report.

Line 8.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306 - 324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedule duplicating the documentation requested on Exhibit 1 to support the bad debts claimed.

Exhibit 1 requires the following documentation:

Columns 1, 2, 3, 4 - Patient Names, Health Insurance Claim (HIC) Number, and Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's

bill. Furnish the patient's name, HIC number and dates of service that correlate to the claimed bad debt. (See CMS Pub. 15-1, chapter 3, §314 and 42 CFR 413.89.)

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Columns 5 & 6--Indigency/Medicaid Beneficiary.--If the patient included in column 1 has been deemed indigent, place a check in column 5. If the patient in column 1 has a valid Medicaid number, include this number in column 6. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322 and 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiary.

Columns 7 & 8--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased.--This information should be obtained from the FQHC's files and should correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit. The date in column 8 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See 42 CFR 413.89(e) and (f), and CMS Pub. 15-1, chapter 3, §§308, 310, and 314.)

Column 9--Medicare Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name, HIC number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit.

Column 10--Coinsurance/Total Medicare Bad Debts.--Record on each line of this column the beneficiary's unpaid coinsurance amount that relates to covered services. Calculate the total bad debts by summing up the amounts on all lines of column 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

Line 9.--Indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the revised bad debt collection policy with the cost report.

Line 10.--Indicate whether patient coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 11.--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement (PS&R) Report only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and visits found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 12.--Indicate whether the cost report was prepared using the PS&R for totals and the FQHC's records for allocation. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R used to prepare this cost report in column 2. Also, submit a detailed crosswalk between revenue codes and visits on the PS&R to the cost center groupings on the cost report. This crosswalk must show visits by cost center and include which revenue codes were allocated to each cost center. The total visits on the cost report must match the total visits on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the FQHC's records.

Line 13.--If you entered "Y" on either line 11 or 12, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 14.--If you entered "Y" on either line 11 or 12, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 15.--If you entered "Y" on either line 11 or 12, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 16.--Indicate whether the cost report was prepared using FQHC records only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detail documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.
- A reconciliation of remittance totals to the provider's internal records.

- The name of the system used and system maintainer (vendor or FQHC). If the FQHC maintained the system, include date of last software update.

NOTE: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

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Line 17.--Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 18.--Enter the employer/company name of the cost report preparer.

Line 19.--Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

		Dates of Service		Indigency & Medicaid Beneficiary (Check if applicable)					
						Date First Bill Sent to Beneficiary	Date Collection Efforts Ceased	Medicare Remittance	Co-Insurance/ Total Medicare Bad Debts*

*These amounts must not be claimed unless the FQHC bills for these services with the intention of receiving payment.

See instructions for columns 5 and 6 - Indigency/Medicaid Beneficiary, for possible exception.

These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

4407. WORKSHEET S-3 - FEDERALLY QUALIFIED HEALTH CENTER DATA

This worksheet consists of three parts:

Part I - Federally Qualified Health Center Statistical Data

Part II - Federally Qualified Health Center Contract Labor and Benefit Cost

Part III - Federally Qualified Health Center Employee Data

4407.1 Part I - Federally Qualified Health Center Statistical Data.--This part collects statistical data regarding the number and types of visits by title, as well as, the number of visits performed by interns and residents. Only those visits that **qualify as a face to face encounter** associated with a beneficiary receiving services under the Medicare fee for service program are included in column 2. Visits attributable to beneficiaries enrolled in a Medicare Advantage plan must be included in column 4. For the purposes of the Medicare program, a beneficiary who receives care at an FQHC can be seen for three types of visits:

- Medical Visit - **A face to face encounter between an FQHC patient and one of the following: a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse, registered dietician, or certified DSMT/MNT educator.**
- Medical Visit for Subsequent Illness or Injury
- Mental Health Visit - **A face to face encounter between an FQHC patient and one the of the following: a clinical psychologist, clinical social worker, or a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse for mental health services.**

All visits performed by interns and residents who are funded by a THC or PCRE grant from HRSA must be excluded from lines 5 and 6 on this worksheet. Visits performed by an intern or resident funded by a THC or PCRE grant from HRSA are separately reported on the Worksheet S-1, Parts I and II.

~~An FQHC must report comparable visits for title X and title XIX and other payors in their respective columns.~~

Column 0.--Use this column only when you are filing a consolidated cost report to identify each FQHC listed on Worksheet S-1, Part I, line 14 and subscripts in the exact same order.

Columns 1 through 4.--Enter the number of medical visits, mental health visits and visits performed by interns and residents, if applicable, for each program (title V, title XVIII, and title XIX) **and all other payors**. Include dually eligible (Medicare/Medicaid) beneficiaries in column 2.

Column 5.--Enter the sum of the total medical visits, mental health visits and visits performed by interns and residents included in columns 1 through 4.

Line 1.--Enter the number of medical visits applicable to columns 1 through 4. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the FQHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 1 must contain the medical visits exclusively for the primary CCN and you must subscript line 1 to report the number of medical visits for each additional FQHC included in this consolidated cost report. Each subscript of line 1, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14 and subscripts in the exact same order. Enter the number of medical visits applicable to columns 1 through 4, for each FQHC listed on line 1 and its subscripts.

Line 2.--Enter the total number of medical visits (sum of line 1 and its subscripts) for each applicable column.

Line 3.--Enter the number of mental health visits applicable to columns 1 through 4. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary

returns to the FQHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 3 must contain the mental health visits exclusively for the primary CCN and you must subscript line 3 to report the number of mental health visits for each additional FQHC included in this consolidated cost report. Each subscript of line 3, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14 and subscripts in the exact same order. Enter the number of mental health visits applicable to columns 1 through 4, for each FQHC listed on line 3 and its subscripts.

Line 4.--Enter the total number of mental health visits (sum of line 3 and its subscripts) for each applicable column.

Line 5.--Enter the total number of visits performed by interns and residents not funded by a THC or PCRE grant from HRSA applicable to columns 1 through 4. If you are filing under a consolidated cost report, line 5 must contain the visits performed by interns and residents exclusively for the primary CCN and you must subscript line 5 to report the number of visits performed by interns and residents for each additional FQHC included in this consolidated cost report. Each subscript of line 5, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14 and subscripts in the exact same order. Enter the number of visits performed by interns and residents applicable to columns 1 through 4 for each FQHC listed on line 5 and its subscripts.

Line 6.--Enter the total number of visits performed by interns and residents not funded by a THC or PCRE grant from HRSA (sum of line 5 and its subscripts) for each applicable column.

Column 5.--Enter the sum of the total medical visits, mental health visits and visits performed by interns and residents included in columns 1 through 4.

NOTE: When reporting data for FQHCs reporting under the consolidated cost reporting provisions, subscript lines 1, 3, and 5 in the identical sequence that the consolidated FQHCs are reported on Worksheet S-1, Part I, line 14.

~~4407.2—Part II-- Federally Qualified Health Center Contract Labor and Benefit Cost.--This section identifies the contract labor and benefit costs relating to direct patient care and top-level management services.~~

~~DEFINITIONS~~

~~-~~

~~Column 1--Contract Labor Costs.--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care and top-level management services for the~~

~~occupations on lines 1 through 13. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).~~

~~Column 2 - Benefit Costs. Enter the amount of employee benefit costs, also referred to as wage-related costs, for services furnished under contract, rather than by employees, for direct patient care and top level management services for the occupations listed on lines 1 through 13.~~

~~-~~

4407.2 Part II - Federally Qualified Health Center Contract Labor and Benefit Cost.--This section identifies the contract labor and benefit costs relating to direct patient care, ~~and top-level management services.~~ See Worksheet A for the applicable cost center Use the definitions that apply to the occupations used to complete the Worksheet A here.

DEFINITIONS

Column 1 - Contract Labor Costs.--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care and management services for the occupations on lines ~~24~~ through 15. Line 1 is the aggregate of lines 2 through 15. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Column 2 - Benefit Costs.--Enter the amount of employee benefit costs, also referred to as wage-related costs, ~~for services furnished under contract, rather than by employees,~~ for direct patient care ~~management~~ services for the occupations listed on lines ~~24~~ through 15. Line 1 is the aggregate of lines 2 through 15.

4407.3 Part III - Federally Qualified Health Center Employee Data.--This section identifies data related to the human resources of the FQHC. The human resources statistics are required for each of the job categories specified in lines ~~164~~ through 29.

Enter the number of hours in your normal work week.

Report in column 1 the FTE employees on the FQHC's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the FQHC.

Complete staff FTEs for column 1 as follows: Add all hours for which employees were paid and divide by 2080. Round to two decimal places, e.g., 04447 is rounded to .04. Compute contract FTE's for column 2 as follows: Add all hours for which contracted and consultant staff worked and divide by 2080 hours. If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Enter the total FTEs in column 3, by adding columns 1 and 2.

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4408. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL
BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers listed may not apply to every FQHC using these forms. For example, a FQHC that does not have an intern and resident program will not complete lines 47 and/or 78. Complete only those lines that are applicable.

If the cost elements of a cost center are maintained separately on your accounting books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained and are subject to review by your contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If additional or different cost center descriptions are needed, add (subscript) additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care entities on the Medicare cost reports. Form CMS-224-14 provides for preprinted cost center descriptions on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software. These cost center descriptions are hereafter referred to as the standard cost centers. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

This coding methodology allows FQHCs to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each FQHC's label in the ECR file provide standardized meaning for data analysis. FQHCs are required to compare any added or changed labels to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4495, table 5.

COLUMN DESCRIPTIONS

Columns 1 through 3.--The expenses listed in these columns must be in accordance with your accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3.

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include paid vacation, holiday, sick, other-paid-time off, severance and bonus pay. (See CMS Pub. 15-1, chapter 21.) Enter salaries from the FQHC's accounting books and records.

Column 2.--Enter all costs other than salaries from the FQHC's accounting books and records.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each cost center, enter the net amount of reclassifications from Worksheet A-1. The net total of the entries in column 4 must equal zero on line 100. Show reductions to expenses as negative numbers.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4. The total on column 5, line 100 must equal the total on column 3, line 100.

Column 6.--For each cost center, enter the net of any increase and decrease amounts from Worksheet A-2. The total on Worksheet A, column 6, line 100 must equal Worksheet A-2, column 2, line 50.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6.

LINE DESCRIPTIONS

The Worksheet A segregates the trial balance of expenses into general service cost centers, direct patient care cost centers, reimbursable pass through costs, other FQHC services, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets.

GENERAL SERVICE COST CENTERS

These cost centers include expenses incurred in operating the FQHC as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers in the FQHC.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fix and Cap Rel Costs-Mvble Equip.--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including depreciation, leases and rentals for the use of facilities and/or equipment, including electronic health records systems, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, taxes on land or depreciable assets used for patient care, and software and hardware updates attributable to electronic health records systems. Do not include in these cost centers costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

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Line 3 - Employee Benefits.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when an FQHC's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144).

Line 4 - Administrative and General (A&G) Services.--A&G includes a wide variety of administrative costs such as but not limited to cost of fiscal services, legal and accounting services, facility administrative services (not already included in other general services cost centers), etcetera.

Line 5 - Plant Operation and Maintenance.--This cost center includes expenses incurred in the plant operation and maintenance of the FQHC. These costs include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes costs incurred in maintaining the facility and grounds, such as costs of routine painting, plumbing, mowing, and snow removal.

Line 6 - Janitorial.--This cost center includes the cost of routine janitorial activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 7 - Medical Records.--This cost center includes the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center. None of the costs associated with electronic health records systems are reported in this cost center.

Line 8 - Subtotal - Administrative Overhead.--Enter the total of lines 1 through 7.

Line 9 - Pharmacy.--This cost center includes only the costs of routine drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel, and pharmacy services, provided incident to an FQHC visit. Drugs and pharmacy supplies that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Part B, C, or D of Medicare must be included on line 67 (Drugs Charged to Patients) of this worksheet. Drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services provided by a retail pharmacy are reported on line 77. Do not include the cost of pneumococcal and influenza vaccines on this line as these costs are reported on lines 48 and 49, respectively.

Line 10 - Medical Supplies.--This cost center includes the routine cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, and the non-routine costs of medical supplies that can be traced to individual patients. Do not include the cost of medical supplies used in administering influenza and pneumococcal vaccines on this line as these costs are reported on lines 48 and 49, respectively.

Line 11 - Transportation.--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other FQHC business.

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Line 12 - Other General Service (Specify).--Use this line to report the costs of other general service costs not previously identified on lines 1 through 11. If more than one other general service is offered, subscript this line. See Table 5 in §4495 for the proper cost center code for this line.

Line 13 - Subtotal - Total Overhead.--Enter the sum of lines 8 and 9 through 12.

Line 14 through 22.--Reserved for future use.

DIRECT CARE COST CENTERS

Line 23 - Physician.--This cost center includes the costs incurred by the FQHC for physicians providing direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the governing board. Reclassify the cost for the portion of time physicians spent on general supervisory services or other FQHC administrative activities to A&G (line 4). The costs incurred for teaching physicians and interns and residents must be reported on line 47 or line 48, whichever is applicable.

Line 24 - Physician Services Under Agreement.--This cost center includes the costs incurred by the FQHC for physicians who are providing services under agreement.

Line 25 - Physician Assistant.--This cost center includes the costs incurred by the FQHC for physician assistants (PA), including the costs for PAs providing physician services.

Line 26 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners (NP), including NPs providing physician services.

Line 27 - Visiting Registered Nurse.--This cost center only includes the costs of nursing care provided by registered nurses (RNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with RNs who provide services incident to a physician, PA, NP, certified nurse midwife (CNM), clinical psychologist (CP) or clinical social worker (CSW) (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140) are included in line 36.

Line 28 - Visiting Licensed Practical Nurse.--This cost center only includes the costs of nursing care provided by licensed practical nurses (LPNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with LPNs that provide services incident to a physician, PA, NP, CNM, CP or CSW (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140) are included in line 36.

Line 29 - Certified Nurse Midwife.--This cost center includes the costs of nursing care provided by CNMs.

Line 30 - Clinical Psychologist.--This cost center includes the costs of a CP who holds a doctorate in psychology and is licensed or certified by the State in which he or she practices, for diagnostic, assessment, preventative and therapeutic services directed at individuals.

Line 31 - Clinical Social Worker.--This cost center includes the costs of a CSW who possesses a master's degree or doctorate in social work and meets specified criteria established by regulation. The CSW must directly examine the patient, or directly review the patient's medical information, to provide diagnosis, treatment and consultation.

Line 32 - Laboratory Technician.--This cost center includes the costs of a person who, under the supervision of a medical technologist or physician, performs microscopic and bacteriologic tests of human blood, tissue, and fluid for diagnostic and research purposes.

Line 33 - Reg Dietician/Cert DSMT/MNT Educator.--This cost center includes the costs of a person who is either a registered dietician or nutritionist who meets specified criteria for providing diabetes self-management training (DSMT) or medical nutrition therapy (MNT) services under the Program.

Line 34 - Physical Therapist.--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 35 - Occupational Therapist.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 36 - Other Allied Health Personnel.--This cost center includes the costs of RNs and LPNs who provide services incident to a physician, PA, NP, CNM, CP or CSW in accordance with CMS Pub. 100-02, chapter 13, §§110, 120 or 140 and the costs of other allied health personnel that provide diagnostic, technical, therapeutic and direct patient care and support services to the other health professionals they work with and the patients they serve. An example of other allied health personnel is a medical assistant.

Line 37 - Subtotal Direct Patient Care Services.--Enter the total of lines 23 through 36.

Line 38 through 46.--Reserved for future use.

REIMBURSABLE PASS THROUGH COSTS

Line 47 - Allowable GME Costs.--This cost center includes the costs associated with allowable direct GME costs set forth in 42 CFR 405.2468(f). These include residents' salaries and fringe benefits (including travel and lodging expenses where applicable); the allowable portion of the teaching physicians' salaries and fringe benefits that are related to the time spent teaching and

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supervising residents (i.e., lecture time, time spent filling out resident evaluations, mentoring, and program development) subject to the reasonable compensation equivalency limits (RCEs) (42 CFR 415.70); and overhead costs that are directly assigned to the intern and resident program, excluding all overhead included in the general service cost centers paid under the FQHC PPS.

An FQHC must include all allowable direct costs associated with an intern and/or resident program funded by a THC and/or PCRE grant from HRSA on line 47, only if the program meets the requirements set forth in 42 CFR 405.2468(f). If the direct costs associated with an intern and/or resident who is funded by a THC and/or PCRE grant are included in line 47, the FQHC must reclassify the direct costs associated with the THC and/or PCRE programs funded by HRSA to line 78, nonallowable GME costs.

A "moonlighting" resident or fellow is a postgraduate medical trainee who is practicing independently, outside the scope of his or her residency training program and would be treated as a physician within the scope of the privileges granted by the FQHC. Therefore, costs associated with a "moonlighting" intern or resident are reported in the physician services cost center, not the allowable GME cost center.

Line 48 - Pneumococcal Vaccines & Med Supplies.--This cost center includes the cost of the pneumococcal vaccines and the medical supplies attributable to pneumococcal vaccinations.

Line 49 - Influenza Vaccines & Med Supplies.--This cost center includes the cost of the influenza vaccines and the medical supplies attributable to influenza vaccinations.

Line 50 - Subtotal - Reimbursable Pass Through Costs.--Enter the total of lines 47 through 49.

Line 51 through 59.--Reserved for future use.

OTHER FQHC SERVICES

Line 60 - Medicare Excluded Services.--This cost center includes the cost of routine dental care, hearing tests, eye exams, etc. that are excluded from coverage under the Program.

Line 61 - Diagnostic & Screening Lab Tests.--This cost center includes the technical component of diagnostic and laboratory tests such as electrocardiograms and certain preventative services authorized by the Medicare statute or the national coverage determination process. (The professional component is a FQHC service if performed by an FQHC practitioner or furnished incident to an FQHC service). This does not include venipuncture, which is included in the pharmacy cost center when furnished by the FQHC.

Line 62 - Radiology - Diagnostic.--This cost center includes the technical component of radiological diagnostic tests such as x-rays and imaging services.

Line 63 - Prosthetic Devices.--This cost center includes the costs of devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), replacement of such devices, and one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with the insertion of an intraocular lens.

Line 64 - Durable Medical Equipment.--This cost center includes the direct costs of durable medical equipment rented or sold (DME, as defined in 42 CFR 410.38) furnished to an individual patient and all direct expenses incurred in requisitioning and issuing DME to patients.

Line 65 - Ambulance Services.--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscribing is allowed for this line.

Line 66 - Telehealth.--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §190.

Line 67 - Drugs Charged to Patients.--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Medicare Parts B, C, or D.

Line 68 - Other (Specify).--Use this line to report the costs of other FQHC services not previously identified on lines 60 through 67. If more than one other service is offered, subscript this line. See Table 5 in §4495 for the proper cost center code for this line.

Line 69 - Subtotal Other FQHC Services.--Enter the total of lines 60 through 68.

NONREIMBURSABLE COST CENTERS

Line 70 through 76.--Reserved for future use.

Line 77 - Retail Pharmacy.--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that are sold through a retail pharmacy.

Line 78 - Nonallowable GME Costs.--This cost center includes the costs associated with an intern and resident program not approved by Medicare.

Line 79 - Other Nonreimbursable (Specify).--Use this line to record the costs applicable to other nonreimbursable cost centers not provided for on this worksheet.

| Line 80 - Subtotal of Nonreimbursable Cost Centers.--Enter the total of lines 77 through 79.

Line 81 through 99.--Reserved for future use.

| Line 100 - Total.--Enter the sum of lines 13, 37, 50, 69 and 80.

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4409. WORKSHEET A-1 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain amounts to effect the proper cost allocation. The cost centers affected must be specifically identifiable in your accounting records. Use reclassifications in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet A are maintained in your accounting books and records in one cost center.

Column 1.--Identify each reclassification adjustment by assigning an alpha character (e.g., A, B, C) in column 1. Do not use numeric designations.

Columns 2, 3, and 4.--For each increase reclassification, enter the corresponding cost center description in column 2, the Worksheet A cost center line number reference in column 3, and reclassification amount in column 4.

Columns 5, 6, and 7.--For each decrease reclassification, enter the corresponding cost center description in column 5, the Worksheet A cost center line number reference in column 6, and reclassification amount in column 7.

4410. WORKSHEET A-2 - ADJUSTMENTS TO EXPENSES

This worksheet provides for adjusting the expenses listed on Worksheet A, column 5. Make these adjustments, which are required under the Medicare principles of reimbursement, on the basis of cost, or amount received. Enter the total amount received (revenue) only if the cost (including the direct cost and all applicable overhead) cannot be determined. However, if total direct and indirect cost can be determined, enter the cost. Once an adjustment to an expense is made on the basis of cost, you may not, in future cost reporting periods determine the required adjustment to the expense on the basis of revenue. Enter the following symbols in column 1 to indicate the basis for adjustments: "A" for costs and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items to be entered on this worksheet are (1) those needed to adjust expenses incurred, (2) those items which constitute recovery of expenses through sales, charges, fees, etc., and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See CMS Pub. 15-1, §2328.)

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Columns 2, 3 and 4.--For each adjustment, enter the amount in column 2, enter the Worksheet A cost center line number reference in column 4, and enter the corresponding cost center description in column 3.

Lines 1 through 3.--Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs. (See CMS Pub. 15-1, chapter 2.)

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Apply the investment income on restricted and unrestricted funds which are commingled with other funds against the administrative and general, the capital-related - buildings and fixtures, the capital-related - moveable equipment and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charged to all of your cost centers.

Line 7.--Enter the amount from Worksheet A-2-1, column 6, line 5.

Line 10.--Enter the amount which represents the allowable cost of the services furnished by Public Health Service personnel. Obtain this amount from your contractor.

Lines 11 and 12.--If depreciation expense computed in accordance with Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 11 and/or 12.

Line 13.--Enter RCE adjustment for teaching physicians. RCE limits apply to the portion of the teaching physician's salary associated with teaching residents (i.e., lecture time, time spent filling out resident evaluations, mentoring, and program development, etcetera as these activities are "direct GME" activities). See CMS Pub. 15-1, chapter 21.

Line 14 through 49.--Enter any additional adjustments required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments.

Line 50.--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to the appropriate lines on Worksheet A, column 6.

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4411.2

4411. WORKSHEET A-2-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the FQHC by organizations related to the FQHC by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the FQHC by organizations related to the FQHC or costs associated with the home office. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

4411.1 Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs.--This part of the worksheet provides for the computation of adjustments needed to properly report costs of services, facilities, and supplies furnished to the FQHC by related organizations or costs associated with the home office.

Columns 1 and 2.--Enter in column 1 the Worksheet A cost center line number to be adjusted. Enter the corresponding cost center description in column 2.

Column 3.--Enter the description of the related organization or home office expense.

Column 4.--Enter the allowable costs from the books and/or records of the related organization or home office. Allowable costs are the actual costs incurred by the related organization or home office for services, facilities, and/or supplies and exclude any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 5.--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations and/or home office.

Column 6.--Enter the result of column 4 minus column 5.

4411.2 Part II - Interrelationship to Related Organizations and/or Home Office.-- This part of the worksheet identifies the interrelationship between the FQHC and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the FQHC as defined in CMS Pub. 15-1, chapter 10. Complete columns 1 through 6 as applicable for each interrelationship.

Complete only those columns that are pertinent to the type of relationship that exists.

Column 1.--Enter the symbol that represents the interrelationship between the FQHC and the related organization or home office. Select from the following choices:

<u>Symbol</u>	<u>Relationship</u>
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider
B	Corporation, partnership or other organization has financial interest in provider
C	Provider has financial interest in corporation, partnership, or other organization
D	Director, officer, administrator or key person of provider or organization
E	Individual is director, officer, administrator or key person of provider and related organization
F	Director, officer, administrator or key person of related organization or relative of such person has financial interest in provider
G	Other (financial or non-financial) -- specify

Column 2.--If the symbol entered in column 1 is A, D, E, F, or G, enter the name of the related individual in column 2.

Column 3.--If the individual reported in column 2, or the organization reported in column 4, has a financial interest in the FQHC, enter the percent of ownership.

Column 4.--Enter the name of each related corporation, partnership, or other organization.

Column 5.--If the FQHC, or an individual reported in column 2, has a financial interest in the organization reported in column 4, enter the percent of ownership.

Column 6.--Enter the type of business of the related organization (e.g., medical drugs and/or supplies, janitorial services).

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4412.1

4412. WORKSHEET B - CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS

Worksheet B consists of two parts. Part I is used to summarize (1) the FQHC medical and mental health visits furnished by practitioners, including health care staff and physicians under agreement, and (2) apportion overhead costs to FQHC services to determine the cost per visit for a medical visit and a mental health visit, by practitioner. Part II is used to determine the FQHC's Medicare reimbursable direct GME costs, where applicable.

4412.1 Part I - Calculation of Federally Qualified Health Center Cost Per Visit.--The purpose of Part I is to establish the FQHC medical and mental health Medicare cost per visit.

Column 1.--Enter the total cost for each practitioner from Worksheet A, column 7 as indicated on the worksheet.

Column 2.--Enter the total medical and mental health visits actually furnished to all patients by each practitioner during the cost reporting period. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the FQHC in the same day for a subsequent illness or injury. A beneficiary can have up to three medical visits in a day to include the initial visit and two subsequent visits for illness or injury.

NOTE: Column 2, line 11 must equal Worksheet S-3, Part I, column 5, sum of lines 2 and 4. For each line 1 through 10, column 2 must equal the sum of columns 7 and 8.

Column 3.--Use this column to allocate costs associated with other direct care costs, sum of Worksheet A, column 7, lines 9, 32, and 34 through 36. Calculate the unit cost multiplier (UCM) related to other direct care costs by dividing the sum of Worksheet A, column 7, lines 9, 32, 34, 35, and 36, by Worksheet B, Part I, column 2, line 11, total medical and mental health visits, and enter the result on line 12. Calculate the costs for lines 1 through 10 by multiplying the visits on each corresponding line, column 2, times the UCM on line 12.

Column 4.--Use this column to allocate general service costs, on Worksheet A, column 7, line 13, minus line 9. Calculate the UCM by dividing Worksheet A, column 7, line 13, minus line 9, by Worksheet A, column 7, line 100, minus line 13, and enter the result on line 12. Allocate the general service cost attributable to each practitioner on lines 1 through 10, by multiplying the UCM times the sum of the amounts in columns 1 and 3, for each corresponding line.

Column 5.--Enter the sum of columns 1, 3, and 4 for each practitioner.

Column 6.--Calculate the average cost per visit by each practitioner by dividing the total cost in column 5 by the total visits in column 2. Enter the result in column 6.

Column 7.--Enter the total number of medical visits, included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 8.--Enter the total number of mental health visits, included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 9.--Enter the total number of medical visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

Column 10.--Enter the total number of mental health visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

NOTE: Worksheet S-3, Part I, column 2, line 2, must equal column 9, line 11; and Worksheet S-3, Part I, column 2, line 4, must equal column 10, line 11.

Column 11.--Calculate the Medicare cost per medical visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 9.

Column 12.--Calculate the Medicare cost per mental health visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 10.

Line 11.--Enter the sum of lines 1 through 10 for the applicable columns.

Line 13, column 6.--Calculate the FQHC average cost per visit by dividing column 5, line 11 by column 2, line 11.

Line 13, column 11.--Calculate the Medicare average cost per medical visit by dividing column 11, line 11 by column 9, line 11.

Line 13, column 12.--Calculate the Medicare average cost per mental health visit by dividing column 12, line 11 by column 10, line 11.

4412.2 Part II - Calculation of Allowable Direct Graduate Medical Education Costs.--The purpose of Part II is to calculate the allowable cost of direct GME costs that will be reimbursed by the Medicare program.

Column 1--Enter the total amount of direct GME cost from Worksheet A, column 7, line 47.

Column 2--Enter the total number of visits performed by interns and residents from Worksheet S-3, Part I, line 6, column 5.

Column 3--Enter the total number of title XVIII visits performed by interns and residents from Worksheet S-3, Part I, line 6, column 2.

Column 4--Divide column 3, by column 2. Enter the result in column 4 and round to six decimal places.

Column 5--Multiply the amount in column 1 by the result in column 4. Enter the result in column 5. This is the amount that Medicare will reimburse the FQHC for its direct GME activities.

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4413. WORKSHEET B-1 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

The cost and administration of pneumococcal and influenza vaccines to Medicare beneficiaries are 100 percent reimbursable by Medicare. This worksheet provides for the computation of the cost of the pneumococcal and influenza vaccines.

Line 1--Enter the health care staff cost from Worksheet A, column 7, sum of lines 23, and 25 through 36, in columns 1 and 2, as applicable. Physician services under agreement are excluded from this total.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician services under agreement time in this calculation. Obtain the estimated percentage of time spent from your accounting books and records.

Line 3.--Multiply the amount on line 1 by the amount on line 2 and enter the result.

Line 4.--Enter the cost of pneumococcal and influenza vaccines and the cost of related medical supplies from Worksheet A column 7, lines 48 and 49, in columns 1 and 2, respectively.

Line 5.--Enter the sum of lines 3 and 4.

Line 6.--Enter the total direct costs of the FQHC from Worksheet A, column 7, line 100.

Line 7.--Enter the administrative overhead of the FQHC from Worksheet A, column 7, line 8.

Line 8.--Divide the amount on line 5 by the amount on line 6 and enter the result.

Line 9.--Multiply the amount on line 7 by the ratio on line 8 and enter the result.

Line 10.--Enter the sum of the amounts on lines 5 and 9.

Line 11.--Enter in columns 1 and 2 respectively, the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Compute the FQHC cost per pneumococcal and influenza vaccine injection by dividing the costs on line 10 by the number of injections on line 11 and entering the result.

Line 13.--Enter from your records the number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries, in columns 1 and 2 respectively.

Line 14.--Enter the Medicare cost per pneumococcal and influenza vaccine injection by multiplying the cost per vaccine on line 12 by the number of injections administered to Medicare beneficiaries on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccines and their administration by entering the sum of the amounts in columns 1 and 2, line 10.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration by entering the sum of the amount in columns 1 and 2, line 14. Transfer this amount to the Worksheet E, line 3.

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4414. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of FQHC services rendered to program patients under the FQHC PPS. It also provides for an accumulation of cost reimbursable direct graduate medical education payments, pneumococcal and influenza vaccine reimbursement, and Medicare Advantage (MA) supplemental payments.

Line 1.--FQHC services are paid in accordance with FQHC PPS. Enter the total PPS payments paid for FQHC visits rendered during the cost reporting period. Obtain this amount from the provider statistical and reimbursement (PS&R) report.

Line 2.--Enter the Medicare costs for direct graduate medical education from Worksheet B, Part II, line 14, column 5.

Line 3.--Enter the Medicare costs for pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 4.--Medicare advantage supplemental payments are made to an FQHC when the amount paid by the managed care organization is less than the amount paid under the FQHC PPS on a per visit basis. Enter the total amount of Medicare advantage supplemental payments from the PS&R, report type 778. This data is captured for information purposes only and does not impact cost report settlement.

Line 5.--Enter the sum of lines 1 through 3.

Line 6.--Enter the primary payer amounts from the PS&R.

Line 7.--Enter the result of line 5 minus line 6.

Line 8.--Enter the Part B coinsurance.

Line 9.--Enter the result of line 7 minus line 8.

Line 10.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 10 and 11 will be negative.

Line 11.--Multiply the amount (including negative amounts) from line 10 by 65 percent.

Line 12.-- Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 10.

Line 13.--Enter the sum of lines 9 and 11.

Line 14.--Enter any other adjustments. Provide a description in the space provided.

Line 15.--Enter the result of line 13 plus or minus line 14.

Line 16.--Enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 15]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

Line 17.--Enter the result of line 15 minus line 16.

Line 18.--Enter the amount of interim payments from Worksheet E-1, column 2, line 4.

Line 19.--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet E-1, column 2, line 5.99.

Line 20.--Enter the total amount due to/from the program (line 17 minus lines 18 and 19). Transfer this amount to Worksheet S, Part III, column 1, line 1.

Line 21.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

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4415. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO THE FEDERALLY QUALIFIED HEALTH CENTER FOR SERVICES RENDERED

Complete lines 1 through 4 of this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX.

The remainder of this worksheet is completed by your contractor. All amounts reported on this worksheet must be for services rendered during the cost reporting period for which the costs are included in this cost report.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the FQHC. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. Do not include MA supplemental payments on this worksheet. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer this amount to Worksheet E, line 18.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 5 is "5" (AMENDED COST REPORT), THE FQHC MAY COMPLETE THIS SECTION.)

Line 5.--List separately each tentative settlement payment after the cost report is accepted together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening on this line.

Line 6.--Enter the net settlement amount (balance due the FQHC or balance due the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2 the amount from Worksheet E, line 20.

NOTE: On lines 3, 5, and 6, when an FQHC to program amount is due, show the amount and date on which the FQHC agrees to the amount of repayment even though total repayment is not accomplished until a later date.

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. Enter amounts due the program as a negative number. The amount in column 2 must equal the amount on Worksheet E, line 17.

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4416. WORKSHEET F-1 - STATEMENT OF REVENUE AND EXPENSES

This worksheet is prepared from your accounting books and records. It requires the reporting of total patient revenues (specifically including Medicare, Medicaid and other revenues) for the entire FQHC and operating expenses for the entire FQHC. Additional worksheets may be submitted if necessary.

Line 1.--Enter total patient revenue from your accounting books and/or records in columns 1 through 3, by program as indicated. Enter the sum of columns 1 through 3 in column 4.

Line 2.-- Enter total patient revenues not received in column 2. This includes:

Provision for Bad Debts,

Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Enter in column 2, the sum of line 1, column 4 minus line 2, column 2.

Line 4.--Enter in column 2, total operating expenses from Worksheet A, column 3, line 100.

Lines 5 through 10.--Enter any additions to operating expenses in column 1.

Lines 11 through 16.--Enter any subtractions to operating expenses in column 1.

Line 17.--Enter in column 2, the sum of line 4, column 2 and lines 5 through 16, column 1.

Line 18.--Enter in column 2, the sum of line 3, column 2 minus line 17, column 2.

Lines 19 through 31.--Enter all other income as specified in column 1.

Line 32.--Enter in column 2, the sum of the amounts on lines 19 through 31, column 1.

Line 33.--Enter in column 2, the sum of line 18, plus line 32 in column 2.

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Form CMS-224-14 Worksheets

The following is a listing of the Form CMS-224-14 worksheets and the page number location. Changes to worksheets are indicated by redline on this and the subsequent page for this transmittal. Where only the page number changes, no redlining is indicated.

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