

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

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 09/30/2020

RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PARTS I, II & III
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PART I - COST REPORT STATUS

Provider use only	1. <input type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report. 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: _____ 11. Contractors Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____ (Provider Name(s) and Number(s)) for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

	TITLE XVIII	
1 RHC	1	1

The above amount represents "due to" or "due from" the Medicare program.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0107. The time required to complete this information collection is estimated 55 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

RURAL HEALTH CLINIC IDENTIFICATION DATA	CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET S-1 PART I
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PART I - RURAL HEALTH CLINIC IDENTIFICATION DATA

		Provider CCN	CBSA	Date Certified	Type of control (see instructions)	
	1	2	3	4	5	
1	Site Name:					1
2	Street:	P.O. Box:				2
3	City:	State:	Zip Code:	County:		3
4	Cost Reporting Period (mm/dd/yyyy) From:	To:				4

5 Is this RHC part of an entity that owns, leases or controls multiple RHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below. 5

6	Name of Entity:					6
7	Street:	P.O. Box:	HRSA Award Number:			7
8	City:	State:	Zip Code:			8

9 Is this RHC part of a chain organization as defined in §2150 of CMS Pub. 15, Part 1 that claims home office costs in a Home Office Cost Statement? Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain organization's information below. 9

10	Name of Chain Organization:					10
11	Street:	P.O. Box:	Home Office CCN:			11
12	City:	State:	Zip Code:			12

		Y/N	Date Requested	Date Approved	Number of RHCs	
		1	2	3	4	
13	Is this RHC filing a consolidated cost report per CMS Pub. 100-02, chapter 13, §80.2? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 14, beginning with subscripted line 14.01. If column 1 is no, leave line 14 blank. (see instructions)					13

	Site Name	CCN	CBSA	Date Requested	Date Approved	
	1	2	3	4	5	
14	List of Consolidated Providers					14
14.01						14.01

Medical Malpractice

15	Does this RHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.					15
16	If line 15 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.					16
17	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.		Premiums	Paid Losses	Self Insurance	17
18	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than the Malpractice Premiums cost center? Enter "Y" for yes or "N" for no. (see instructions)					18

Miscellaneous

19	Is this RHC and/or any consolidated RHCs 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. (see instructions)					19
20	Have you received an approval for an exception to the productivity standard?					20
21	Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.					21
22	If line 21 is "Y", specify type of operation. (i.e. physicians office, independent laboratory, etc.)					22
23	Identify days and hours by listing the time the facility operates as a RHC next to the applicable day.					23

	Days	Hours of Operation		
		From	To	
		1	2	
23.01	Sunday			23.01
23.02	Monday			23.02
23.03	Tuesday			23.03
23.04	Wednesday			23.04
23.05	Thursday			23.05
23.06	Friday			23.06
23.07	Saturday			23.07

	Days	Hours of Operation		
		From	To	
		1	2	
24.01	Sunday			24.01
24.02	Monday			24.02
24.03	Tuesday			24.03
24.04	Wednesday			24.04
24.05	Thursday			24.05
24.06	Friday			24.06
24.07	Saturday			24.07

		Y/N	Demonstration Type	
		1	2	
25	Did this facility participate in any payment demonstration during this cost reporting period? Enter "Y" for yes or "N" for no. If column 1 is yes, enter the type of demonstration in column 2.			25
26	Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? If yes, complete A-8-1.			26

RURAL HEALTH CLINIC IDENTIFICATION DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-1 PART II
CENTER CCN: _____			

PART I - RURAL HEALTH CLINIC CONSOLIDATED COST REPORT IDENTIFICATION DATA

		Date Certified 2	Type of control (see instructions) 3	Date Decertified 4	V/I Decertification 5	Date of CHOW 6		
1	Site Name:						1	
2	Street:	P.O. Box:					2	
3	City:	State:	Zip Code:	County:			3	
Medical Malpractice								
4	Does this RHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.							4
5	If line 4 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.							5
6	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.			Premiums	Paid Losses	Self Insurance	6	
Miscellaneous								
7	Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.							7
8	If line 7 is "Y", specify type of operation. (i.e. physicians office, independent laboratory, etc.)							8
9	Identify days and hours by listing the time the facility operates as a RHC next to the applicable day.							9
				Hours of Operation				
				From	To			
				1	2			
9.01	Sunday						9.01	
9.02	Monday						9.02	
9.03	Tuesday						9.03	
9.04	Wednesday						9.04	
9.05	Thursday						9.05	
9.06	Friday						9.06	
9.07	Saturday						9.07	
10	Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day.							10
				Hours of Operation				
				From	To			
				1	2			
10.01	Sunday						10.01	
10.02	Monday						10.02	
10.03	Tuesday						10.03	
10.04	Wednesday						10.04	
10.05	Thursday						10.05	
10.06	Friday						10.06	
10.07	Saturday						10.07	

FORM CMS-222-17 (DATE) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4604.2)

RURAL HEALTH CLINIC REIMBURSEMENT QUESTIONNAIRE	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2
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COMPLETED BY ALL RHCs

		Y/N	Date	V/I	
Provider Organization and Operation		1	2	3	
1	Has the RHC changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)				1
2	Has the RHC terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)				2
3	Is the RHC 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 provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

		Y/N	Type	Date	Y/N	
Financial Data and Reports		1	2	3	4	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter Y or N. If N, see instructions. Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (mm/dd/yyyy). Column 4: Are the cost report total expenses and total revenues different from those on the field financial statements? If yes, submit reconciliation.					4

		Y/N	Y/N	
Approved Educational Activities		1	2	
5	Are costs for Intern-Resident programs claimed on the current cost report?			5
6	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.			6
7	Are GME costs directly assigned to cost centers other than Allowable GME Costs on Worksheet A? If yes, see instructions.			7

		Y/N	
Bad Debts		1	
8	Is the RHC seeking reimbursement for bad debts? If yes, see instructions.		8
9	If line 8 is yes, did the RHC's bad debt collection policy change during this cost reporting period? If yes, submit copy.		9
10	If line 8 is yes, were patient coinsurance amounts waived? If yes, see instructions.		10

		Y/N	Date	
PS&R Report Data		1	2	
11	Was the cost report prepared using the PS&R Report only? If column 1 is yes, enter the paid-through date of the PS&R Report used in column 2. (see instructions)			11
12	Was the cost report prepared using the PS&R Report for totals and the RHC's records for allocation? If column 1 is yes, enter the paid-through date in column 2. (see instructions)			12
13	If line 11 or 12 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.			
14	If line 11 or 12 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			
15	If line 11 or 12 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: _____			
16	Was the cost report prepared only using the RHC's records? If yes, see instructions.			

Cost Report Preparer Contact Information			
17	First name: _____	Last name: _____	Title: _____
18	Employer: _____		
19	Phone number: _____	E-mail Address: _____	

RURAL HEALTH CLINIC DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3
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RURAL HEALTH CLINIC STATISTICAL DATA							
	CENTER CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
	0	1	2	3	4	5	
1 Medical Visits							1
2 Total Medical Visits							2
3 Mental Health Visits							3
4 Total Mental Health Visits							4
5 Number of Visits Performed by Interns and Residents							5
6 Total Number of Visits Performed by Interns and Residents							6
7 Total Visits (sum of lines 2 and 4)							7

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES				CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET A			
COST CENTER			SALARIES 1	OTHER 2	TOTAL 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
FACILITY HEALTH CARE STAFF COSTS									
1	0100	Physician							1
2	0200	Physician Assistant							2
3	0300	Nurse Practitioner							3
4	0400	Certified Nurse Midwife							4
5	0500	Registered Nurse							5
6	0600	Licensed Practical Nurse							6
7	0700	Clinical Psychologist							7
8	0800	Clinical Social Worker							8
9	0900	Laboratory Technician							9
10	1000	Other (specify)							10
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)							14
COSTS UNDER AGREEMENT									
15	1500	Physician Services Under Agreement							15
16	1600	Physician Supervision Under Agreement							16
17		Subtotal Under Agreement (sum of lines 15 and 16)							17
OTHER HEALTH CARE COSTS									
25	2500	Medical Supplies							25
26	2600	Transportation (Health Care Staff)							26
27	2700	Depreciation-Medical Equipment							27
28	2800	Malpractice Premiums							28
29	2900	Allowable GME Costs							29
30	3000	Pneumococcal Vaccines & Med Supplies							30
31	3100	Influenza Vaccines & Med Supplies							31
32	3200	Other (specify)							32
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)							38
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)							39
FACILITY OVERHEAD-FACILITY COST									
40	4000	Rent							40
41	4100	Insurance							41
42	4200	Interest On Mortgage Or Loans							42
43	4300	Utilities							43
44	4400	Depreciation-Buildings And Fixtures							44
45	4500	Depreciation-Movable Equipment							45
46	4600	Housekeeping And Maintenance							46
47	4700	Property Tax							47
48	4800	Other (specify)							48
59		Subtotal-Facility Costs (sum of lines 40 through 48)							59

RECLASSIFICATION AND ADJUSTMENT OF TRIAL
BALANCE OF EXPENSES

CCN: _____

PERIOD:
FROM: _____
TO: _____

WORKSHEET A

COST CENTER			SALARIES	OTHER	TOTAL	RECLASSIFI-	RECLASSIFIED	ADJUSTMENTS	NET	
			1	2	(col. 1 + col. 2)	CATIONS	TRIAL BALANCE		EXPENSES FOR	
					3	4	(col. 3 ± col. 4)	6	ALLOCATION	
							5		(col. 5 ± col. 6)	
									7	
FACILITY OVERHEAD-ADMINISTRATIVE COSTS										
60	6000	Office Salaries								60
61	6100	Depreciation-Office Equipment								61
62	6200	Office Supplies								62
63	6300	Legal								63
64	6400	Accounting								64
65	6500	Insurance								65
66	6600	Telephone								66
67	6700	Fringe Benefits And Payroll Taxes								67
68	6800	Other (specify)								68
73		Subtotal-Administrative Cost (sum of lines 60 through 68)								73
74		Total Overhead (sum of lines 59 and 73)								74
COST OTHER THAN RHC SERVICES										
75	7500	Pharmacy								75
76	7600	Dental								76
77	7700	Optometry								77
78	7800	Non-allowable GME Pass Through Costs								78
79	7900	Telehealth								79
80	8000	Chronic Care Management								80
81	8100	Other (specify)								81
86		Subtotal-Cost Other Than RHC (sum of lines 75 through 81)								86
NON-REIMBURSABLE COSTS										
87	8700									87
88	8800									88
89	8900									89
90		Subtotal Non-Reimbursable Costs (sum of lines 87 through 89)								90
100		TOTAL COSTS (sum of lines 39, 74, 86, and 90)								100

RECLASSIFICATIONS		CCN:	PERIOD: FROM: _____ TO: _____		WORKSHEET A-6			
EXPLANATION OF ENTRY	CODE	INCREASES			DECREASES			
	(1)	COST CENTER	LINE NO.	AMOUNT (2)	COST CENTER	LINE NO.	AMOUNT (2)	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34								34
35								35
100	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)							100

- (1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
- (2) Transfer the amounts in columns 4 and 7 to Worksheet A, column 4, lines as appropriate.

ADJUSTMENTS TO EXPENSES		CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8	
DESCRIPTION (1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
			COST CENTER	LINE #	
			1	2	
1	Investment income- buildings and fixtures (chapter 2)		Buildings and Fixtures	44	1
2	Investment income- movable equipment (chapter 2)		Movable Equipment	45	2
3	Investment income- other (chapter 2)				3
4	Trade, quantity and time discounts (chapter 8)				4
5	Refunds and rebates of expenses (chapter 8)				5
6	Rental of building or office space to others (chapter 8)				6
7	Related organization transactions (chapter 10)	Wkst A-8-1			7
8	Sale of drugs to other than patients				8
9	Vending machines				9
10	Practitioner assigned by Public Health Service				10
11	Depreciation - buildings and fixtures		Buildings and Fixtures	44	11
12	Depreciation - movable equipment		Movable Equipment	45	12
13	RCE adjustment to teaching physician's cost		Allowable GME Costs	29	13
14	Other adjustments (Specify)(3)				14
50	TOTAL (sum of lines 1 through 49)				50

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
- (2) Basis for adjustment (see instructions)
 - A. Costs - if cost, including applicable overhead, can be determined.
 - B. Amount Received - if cost cannot be determined.
- (3) Additional adjustments may be made on lines 14 through 49 and subscripts thereof.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-1
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PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount included in Wkst. A, col. 5	Net Adjustments (col. 4 minus col. 5) *	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer col. 6, line 5 to Wkst. A-8 , column 2, line 7.)						5

* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

PART II - INTERRELATIONSHIP TO RELATED ORGANIZATIONS AND/OR HOME OFFICE

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

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

	Symbol (1)	Name	Related Organization(s) and/or Home Office				
			Percentage of Ownership	Name	Percentage of Ownership	Type of Business	
			3	4	5	6	
6							6
7							7
8							8
9							9
10							10

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in the RHC;
- B. Corporation, partnership, or other organization has financial interest in the RHC;
- C. RHC has financial interest in corporation, partnership, or other organization(s);
- D. Director, officer, administrator, or key person of the RHC or relative of such person has financial interest in related organization;
- E. Individual is director, officer, administrator, or key person of the RHC and related organization;
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in the RHC;
- G. Other (financial or non-financial) specify _____

VISITS AND OVERHEAD COST FOR RHC SERVICES	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B PARTS I & II
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PART I - VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of Col. 2 or Col. 4	
		1	2	3	4	5	
1	Physicians			4200			1
2	Physician Assistants			2100			2
3	Nurse Practitioner			2100			3
4	Certified Nurse Midwife			2100			
5	Subtotal (sum of lines 1 through 4)						5
6	Registered Nurse						6
7	Licensed Practical Nurse						6
8	Clinical Psychologist						8
9	Clinical Social Worker						9
10	Total Staff						10
11	Physician Services Under Agreement						11

(1) Productivity standards established by CMS are: 4200 visits for each physician and 2100 visits for each nonphysician practitioner. If an exception to the productivity standard has been granted (Wkst. S-1, Part 1, line 20, equals "Y"), input in col. 3, lines 1 through 4, the productivity standards derived by the contractor.

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

		Amount	
12	Cost of RHC services - excluding overhead and allowable GME costs (Worksheet A, column 7, line 39, minus Worksheet A, column 7, line 29)		12
13	Cost of other than RHC - excluding overhead (Worksheet A, column 7, sum of lines 86 and 90)		13
14	Cost of all services - excluding overhead - (sum of lines 12 and 13)		14
15	Ratio of RHC (line 12 divided by line 14)		15
16	Total overhead - (Worksheet A, column 7, line 74)		16
17	Overhead applicable to RHC services (line 15 times line 16) (see instructions)		17
18	Total allowable cost of RHC services (sum of lines 12 and 17)		18

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B-1
		PNEUMOCOCCAL 1	INFLUENZA 2	
1	Health care staff cost (from Worksheet A, column 7, line 14)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 multiplied by line 2)			3
4	Vaccines and related medical supplies cost (from Worksheet A, column 7, lines 30 and 31, respectively)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the facility (from Worksheet A, column 7, line 39)			6
7	Total facility overhead (from Worksheet A, column 7, line 74)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 multiplied by line 8)			9
10	Total pneumococcal and influenza vaccine cost and administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from provider records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and administration (line 12 multiplied by line 13)			14
15	Total cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, line 10) Transfer to Worksheet C, Part I, line 2			15
16	Total Medicare cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, line 14) Transfer to Worksheet C, Part II, line 23			16

DETERMINATION OF MEDICARE PAYMENT	CCN: _____ _____	PERIOD: FROM: _____ TO: _____	WORKSHEET C PARTS I & II
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PART I - DETERMINATION OF RATE FOR RHC SERVICES		AMOUNT	
1	Total allowable costs (Worksheet B, Part II, line 18)		1
2	Cost of pneumococcal and influenza vaccine and administration (from Worksheet B-1, line 15)		2
3	Total allowable cost excluding pneumococcal and influenza vaccine (line 1 minus line 2)		3
4	Greater of minimum visits or actual visits by health care staff (from Worksheet B, Part I, column 5, line 10)		4
5	Physicians visits under agreements (from Worksheet B, Part I, column 5, line 11)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7
		Calculation of Limit (1)	
		Payment Limit Period 1	Payment Limit Period 2
8	Maximum rate per visit (see instructions)		8
9	Rate for Medicare covered visits (lessor of line 7 or line 8)		9

PART II - DETERMINATION OF TOTAL PAYMENT		Payment Limit Period 1	Payment Limit Period 2
10	Medicare covered visits excluding mental health services (from contractor records)		10
11	Medicare cost excluding costs for mental health services (line 9 multiplied by line 10)		11
12	Medicare covered visits for mental health services (from contractor records)		12
13	Medicare covered cost for mental health services (line 9 multiplied by line 12)		13
14	Total Medicare cost (line 11 plus line 13)		14
15	Less: beneficiary deductible (see instructions)		15
16	Net Medicare cost excluding pneumococcal and influenza vaccine and administration (line 14 minus line 15)		16
17	Total Medicare charges (see instructions)		17
18	Total Medicare preventive charges (see instructions)		18
19	Total Medicare preventive costs ((line 18 divided by line 17) times line 14)		19
20	Total Medicare non-preventive costs ((line 16 minus line 19) times 80 percent)		20
21	Net Medicare cost (line 19 plus 20) (see instructions)		21
22	Graduate medical education pass through cost (see instructions)		22
23	Medicare cost of pneumococcal and influenza vaccine and administration (from Worksheet B-1, line 16)		23
24	Net Medicare reimbursement excluding bad debts (sum of lines 21 through 23)		24
25	Allowable bad debts (see instructions)		25
26	Adjusted reimbursable bad debts (see instructions)		26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)		27
28	Subtotal (line 24 plus line 26)		28
29	Other demonstration payment adjustment amount before sequestration		29
30	Other adjustments (specify) (see instructions)		30
31	Amount due RHC prior to sequestration adjustment (line 28 minus lines 29 and 30)		31
32	Sequestration adjustment (see instructions)		32
33	Other demonstration payment adjustment amount after sequestration		33
34	Amount due RHC after sequestration adjustment (line 31 minus lines 32 and 33)		34
35	Interim payments		35
36	Tentative settlement (for contractor use only)		36
37	Balance due RHC/program (line 34 minus lines 35 and 36)		37
38	Protested amounts (nonallowable cost report items) in accordance with 42 CFR 413.24(j)(2)(i)		38

(1) Lines 8 through 16: Fiscal year providers use columns 1 and 2 (and column 3, if applicable); calendar year providers with one rate in effect for the entire cost reporting period use column 2 only.

FORM CMS-222-17 (DATE) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4613 THROUGH 4613.2)

ANALYSIS OF PAYMENTS TO THE RURAL HEALTH CLINIC FOR SERVICES RENDERED		CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET C-1	
Description	Part B				
	mm/dd/yyyy	Amount			
	1	2			
1	Total interim payments paid to RHC			1	
2	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01		3.01
			.02		3.02
			.03		3.03
			.04		3.04
			.05		3.05
		Provider to Program	.50		3.50
			.51		3.51
			.52		3.52
			.53		3.53
			.54		3.54
	.99		3.99		
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. C, Part II, line 35)			4	
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	Program to Provider	.01		5.01
			.02		5.02
			.03		5.03
		Provider to Program	.50		5.50
			.51		5.51
			.52		5.52
	.99		5.99		
6	Determine net settlement amount (balance due) based on the cost report (1)	Program to provider	.01		6.01
		Provider to program	.02		6.02
7	Total Medicare program liability (see instructions)			7	
8	Contractor approving official signature:	Date:		8	

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