04-21			FORM CMS-	224-14		449	0	
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payments made since tr	te beginning of the	cost reporting period bein	g deemed overpayments (42 USC	1395g).		APPROVAL EXPIRES XX-XX-202X		
FEDERALLY OUA	LIFIED HEAL	TH CENTER COST R	EPORT	CCN:	PERIOD:	WORKSHEET S	-	
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PART I - COST RE	PORT STATUS	5					-	
Provider use only		1. [] Elect	conically filed cost report		Date:	Time:	-	
		2. [] Manu	ally submitted cost report					
		3. [] If this	is an amended report enter th	ne number of times the pro	vider resubmitted	l this cost report.		
		4. [] Medi	care Utilization. Enter "F" for	r full, "L" for low, or "N"	for no utilization.			
Contractor	5. [] Cost	Report Status	Date Received:		10. NPR Date:_			
use only	(1) As Su	bmitted	Contractor No.:		11. Contractors	Vendor Code:		
This report is required by lapayments made since the be FEDERALLY QUALIF CERTIFICATION ANI PART I - COST REPOF Provider use only Contractor use only PART II - CERTIFICAT MISREPRESENTATIO ADMINISTRATIVE AG PROVIDED OR PROCI CIVIL AND ADMINIS I HEREBY CE	(2) Settled without audit 8. [] Initial Re			rt for this Provider CCN				
	(3) Settlee	(3) Settled with audit 9. [] Final Re		ort for this Provider CCN times reopened		eopened = 0-9.		
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PART II - CERTIFI	CATION							
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CIVIL AND ADMI	NISTRATIVE A	ACTION, FINES AND	O/OR IMPRISONMENT MA	Y RESULT.				
	CERTIFIC	CATION BY CHIEF F	INANCIAL OFFICER OR A	DMINISTRATOR OF PR	OVIDER(S)			
I HEREBY	Y CERTIFY that	I have read the above	certification statement and th	at I have examined the acc	companying electr	ronically filed or manually		
submitted	cost report and t	he Balance Sheet and	Statement of Revenue and Ex	nenses prepared by		(Provider Name(s)		

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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC	
	1	2	SIGNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Signature date			4

	TITLE XVIII	
	1	
1 FQHC		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 0938-1298. The time required to complete this information collection is estimated 58 hours per response, including the time to review instructions, search existing 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 contraining 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.

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in column 3, enter the total number of visits performed by residents funded by the PCRE grant in this cost reporting period. (see instructions) Image: Contract Contend Contend Contract Contract Contract Contract Contra						in column 1.				25
26 Did this FQHC receive a Teaching Health Center development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, enter in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, only a contract to total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, only a cost of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, only a cost of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, only a cost of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) If yes, only a cost of the total number of visits performed by our FQHC, or is the building or office space provided at no cost to the FQHC? If you own or lease the output of visits performed by residents funded by the THC grant in the amount of rent/lease expense in column 2. If you own or "3" for space provided at no cost in column 1, enter the amount of rent/lease expense in column 2. If you contract Labor Cost If you own or "3" for space provided at no cost in column 1, enter the amount of rent/lease expense in column 2. Contract Labor Cost If you performed					eceived PCRE funding and					
If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Image: Comparison of total number of visits performed by residents funded by the THC grant in the another of remulease expense in column 2. Image: Comparison of total number of visits performed by remultation of the total number of remultation of remultation of the total number of remultation of total number of remultation of the total number of remultation of the total number of remultation of total number of r								_		
in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions) Capital Related Costs - Ownership/Lease of Building Office space occupied by your FQHC, or is the building or office space provided at no cost to the FQHC? Enter "1" for owned, "2" for leased, or "3" for space provided at no cost in column 1, lf you entered "2" in column 1, enter the amount of rent/lease expense in column 2. Contract Labor Cost						mn 1.				26
Capital Related Costs - Ownership/Lease of Building 27 Do you own or lease the building or office space occupied by your FQHC, or is the building or office space provided at no cost to the FQHC? Enter "1" for owned, "2" for leased, or "3" for space provided at no cost in column 1. If you entered "2" in column 1, enter the amount of rent/lease expense in column 2. Contract Labor Cost	-			-	ng period and					
27 Do you own or lease the building or office space occupied by your FQHC, or is the building or office space provided at no cost to the FQHC? Image: Contract Labor Cost 27 Do you own or lease the building or office space occupied by your FQHC, or is the building or office space provided at no cost to the FQHC? Image: Contract Labor Cost Contract Labor Cost Image: Contract Labor Cost Image: Contract Labor Cost			ant in this cost reporting period. (s	see instructions)						
Enter "1" for owned, "2" for leased, or "3" for space provided at no cost in column 1. If you entered "2" in column 1, enter the amount of rent/lease expense in column 2.		0								_
Contract Labor Cost										27
	Enter "1" for owned, "2" for leased, or "	3" for space provided at no cost in column 1. If y	ou entered "2" in column 1, enter th	he amount of rent/lea	ase expense in column 2.					
28 Do you use contract labor to provide medical and/or mental health services to your patients? Enter "V" for yes or "N" for no in column 1	Contract Labor Cost									
20 po you use contract ratio to provide incuter and/or incitian realiti services to your patients: Enter 1 for yes or iv for no in continuit 1.	28 Do you use contract labor to provide me	dical and/or mental health services to your patient	s? Enter "Y" for yes or "N" for no	in column 1.						28

03-	18		FORM C	MS-224-14					4490 (C	Cont.)
FED	ERALLY QUALIFIED HEALTH CENTER IDENTIFICA	FION DATA			CCN:	_	PERIOD: FROM: TO:		WORKSHEET S- PART II	1
PAR	T II - FEDERALLY QUALIFIED HEALTH CENTER CO	NSOLIDATED COST	REPORT PARTICIPANT				10			
					Date	Type of control	Date	V/I	Date of	
					Certified	(see instructions)	Decertified	Decertification	CHOW	
		1		Ī	2	3	4	5	6	
1	Site Name:									1
2	Street:	P.O. Box:								2
3	City:	State:	Zip Code:	County:		Designation - Enter "F	R" for rural or "U" for	urban:		3
FQE	IC Operations	•					1	2	3	
4	What type of organization is this FQHC? If you operate a	as more than one sub-ty	pe of an organization enter	r only the applicab	le alpha					4
	characters in column 2. (see instructions)									
5	Did this FQHC receive a grant under §330 of the PHS Act	during this cost report	ing period? Enter "Y" for	yes or "N" for no.	If yes, complete li	ine 6.				5
6	If the response to line 5 is yes, indicate in column 1, the ty	ne of HRSA grant that	was awarded (see instruction	ons) Enter the dat	e of the grant awa	rd in column 2 and enter				
	the grant award number in column 3. If you received more			onoji Enter the dat	e of the grant and					6
Med	ical Malpractice									
7	Did this FQHC submit an initial deeming or annual redeen no in column 1. If column 1 is yes, enter the effective date	ning application for me e of coverage in columr	dical malpractice coverage 1 2.	under the FTCA v	vith HRSA? Enter	"Y" for yes or "N" for				7
8	Does this FQHC carry commercial malpractice insurance?	Enter "Y" for yes or '	'N" for no.							8
9	Is the malpractice insurance a claims-made or occurrence	policy? Enter "1" for c	claims-made or "2" for occu	urrence policy.						9
		·					Premiums	Paid Losses	Self Insurance	
10	List amounts of malpractice premiums, paid losses or self-	-insurance in the applic	able columns.							10
Inter	rns and Residents									
11	Is this FQHC involved in training residents in an approved	d GME program in acco	ordance with 42 CFR 405.2	2468(f)? Enter "Y'	for yes or "N" for	r no.				11
12	Is this FQHC involved in training residents in an unapprov	ved GME program? Er	nter "Y" for yes or "N" for i	no.						12
13	Did this FQHC receive a Primary Care Residency Expansion	ion (PCRE) grant autho	orized under Part C of Title	VII of the PHS Ac	t from HRSA? E	nter "Y" for yes or "N" fo	or			13
	no in column 1. If yes, enter in column 2 the number of p	orimary care FTE reside	ents that your FQHC traine	d in this cost repor	ting period for wh	ich your FQHC received				
	PCRE funding and in column 3, enter the total number of	1 5	, ,	0	1 01	, ,				
14	Did this FQHC receive a Teaching Health Center develop	0								14
	in column 1. If yes, enter in column 2 the number of FTE	E residents that your FC	HC trained and received fu	unding through yo	ur THC grant in th	is cost reporting				
	period and in column 3, enter the total number of visits pe	rformed by residents fu	inded by the THC grant in	this cost reporting	period. (see instru	uctions)				
	ital Related Costs - Ownership/Lease of Building						1	1		_
15	Do you own or lease the building or office space occupied		0 1		-					15
	Enter "1" for owned, "2" for leased, or "3" for space prov	ided at no cost in colun	nn 1. If you entered "2" in	column 1 enter the	e amount					
	of rent/lease expense in column 2.									
	tract Labor Costs						1			_
16	Do you use contract labor to provide medical and/or ment	al health services to yo	ur patients? Enter "Y" for	yes or "N" for no i	n column 1.					16

FORM CMS-224-14 (03-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4405.2)

4490 (Cont.)		FORM CMS-224-14				0	3-18
FEDERALLY QUALIFIED HEALTH CENT QUESTIONNAIRE		CCN:	PERIOD: FROM: TO:		WORKSHEE	2T S-2	
General Instruction: Enter Y for all YES re Enter all dates in the r		onses.	•		•		
COMPLETED BY ALL FQHCs	iiii/dd/yyyy format.						
				Y/N	Date	V/I	_
Provider Organization and Operation 1 Has the FQHC changed ownership imme	distely prior to the beginning of the	cost reporting period?		1	2	3	1
If yes, enter the date of the change in colu	1mn 2. (see instructions)						
2 Has the FQHC terminated participation in							2
of termination and in column 3, "V" for v 3 Is the FQHC involved in business transac	voluntary or "I" for involuntary. (se	e instructions)					3
(e.g., chain home offices, drug or medica staff, management personnel, or member other similar relationships? (see instructi	l supply companies) that are related s of the board of directors through or	to the provider or its officers, medical					
			Y/N	Trmo	Date	Y/N	
Financial Data and Reports			1	Type 2	3	4	-
4 Column 1: Were the financial statements Column 2: If yes, enter "A" for Audited, date available in column 3. (mm/dd/yyyy Column 4: Are the cost report total expe If yes, submit reconciliation.	"C" for Compiled, or "R" for Revie i)	wed. Submit complete copy or enter					4
					Y/N	Y/N	
Approved Educational Activities					1	2	-
5 Are costs for Intern-Resident programs c							5
6 Was an Intern-Resident program initiated 7 Are GME costs directly assigned to cost	or renewed in the current cost report	rting period? If yes, see instructions.					6
If yes, see instructions.	centers other than Allowable GME C	Losts on Worksneet A?					
						Y/N	
Bad Debts						1	-
8 Is the FQHC seeking reimbursement for							8
9 If line 8 is yes, did the FQHC's bad debt 10 If line 8 is yes, were patient coinsurance			py.				9 10
10 If fine o is yes, were patient consurance	amounts warveu: If yes, see instruct	uons.					10
					Y/N	Date	
PS&R Report Data 11 Was the cost report prepared using the PS	COD Depart and C. If column 1 is us	a anton the			1	2	11
paid-through date of the PS&R Report us		s, enter me					11
12 Was the cost report prepared using the PS	5&R Report for totals and the FQHC						12
If column 1 is yes, enter the paid-through							- 10
13 If line 11or 12 is yes, were adjustments n billed but are not included on the PS&R							13
14 If line 11 or 12 is yes, were adjustments	nade to PS&R Report data for corre	ctions of other					14
PS&R Report information? If yes, see in	structions.						
15 If line 11 or 12 is yes, were adjustments in Describe the other adjustments:	nade to PS&R Report data for Other	r?					15
16 Was the cost report prepared using only t	he FQHC's records? If yes, see inst	ructions.					16
Cost Report Preparer Contact Information							
17 First name:	Last name:			Title:			17
18 Employer:							18
19 Phone number:		E-mail Address:					19

FORM CMS-224-14 (03-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4406)

05-19		FORM CMS-224-14					4490 (4490 (Cont.)	
FEDER	ALLY QUALIFIED HEALTH CENTER DATA		CCN:		PERIOD: FROM: TO:		WORKSHE PART I	ET S-3	
PART	- FEDERALLY QUALIFIED HEALTH CENTER STA	ATISTICAL I	DATA	_					
		CENTER CCN 0	Title V 1	Title XVIII 2	Title XIX 3	Other 4	Total All Patients 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	

FORM CMS-224-14 (04-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4407.1)

4490 (Cont.)	FORM CMS-224-14			()5-19	
FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN:	PERIOD: FROM: TO:		WORKSHEE PART II & III		
PART II - FEDERALLY QUALIFIED HEALTH CENTER CONTRACT LABOR AND BENEFIT COST						
			Contract	Benefit		
			Labor	Cost		
			1	2		

1	Total facility contract labor and benefit cost		1
2	Physician		2
3	Physician Assistant		3
4	Nurse Practitioner		4
5	Visiting Registered Nurse		5
6	Visiting Licensed Practical Nurse		6
7	Certified Nurse Midwife		7
8	Clinical Psychologist		8
9	Clinical Social Worker		9
10	Laboratory Technician		10
11	Reg Dietician/Cert DSMT/MNT Educator		11
12	Physical Therapist		12
13	Occupational Therapist		13
14	Other Allied Health Personnel		14
15	Interns & Residents		15

inter the number of hours in		Number of Employees (Full Time Equivalent)				
our normal work week	Staff	Contract	Total	1		
	1	2	3	1		
16 Physician				16		
17 Physician Assistant				17		
18 Nurse Practitioner				18		
19 Visiting Registered Nurse				19		
20 Visiting Licensed Practical Nurse				20		
21 Certified Nurse Midwife				21		
22 Clinical Psychologist				22		
23 Clinical Social Worker				23		
24 Laboratory Technician				24		
25 Reg Dietician/Cert DSMT/MNT Educator				25		
26 Physical Therapist				26		
27 Occupational Therapist				27		
28 Other Allied Health Personnel				28		
29 Interns & Residents				29		

FORM CMS-224-14 (05-2019) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4407.2 & 4407.

04-21	FORM CMS-2				224-14			
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE O	F EXPENSES		CCN:		PERIOD: FROM: TO:		WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4) 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION (col. $5 \pm$ col. 6) 7	
GENERAL SERVICE COST CENTERS								
1 0100 Cap Rel Costs-Bldg and Fix								1
2 0200 Cap Rel Costs-Mvble Equip								2
3 0300 Employee Benefits								3
4 0400 Administrative & General Services								4
5 0500 Plant Operation & Maintenance								5
6 0600 Janitorial								6
7 0700 Medical Records								7
8 Subtotal - Administrative Overhead								8
9 0900 Pharmacy								9
10 1000 Medical Supplies								10
11 1100 Transportation								11
12 1200 Other General Service (specify)								12
13 Subtotal - Total Overhead								13
DIRECT CARE COST CENTERS								
23 2300 Physician								23
24 2400 Physician Services Under Agreement								24
25 2500 Physician Assistant								25
26 2600 Nurse Practitioner								26
27 2700 Visiting Registered Nurse								27
28 2800 Visiting Licensed Practical Nurse								28
29 2900 Certified Nurse Midwife								29
30 3000 Clinical Psychologist								30
31 3100 Clinical Social Worker								31
32 3200 Laboratory Technician								32
33 3300 Reg Dietician/Cert DSMT/MNT Educator								33
34 3400 Physical Therapist								34
35 3500 Occupational Therapist								35
36 3600 Other Allied Health Personnel								36
37 Subtotal - Direct Patient Care Services								37

4490 (Cont.)		FORM CMS-	224-14					04-21
RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF	F EXPENSES		CCN: PERIOD: FROM TO				WORKSHEET A	
COST CENTER DESCRIPTIONS (omit cents)	SALARIES 1	OTHER 2	TOTAL (col. 1 + col. 2) 3	RECLASSIFI- CATIONS 4	RECLASSIFIED TRIAL BALANCE (col. $3 \pm$ col. 4) 5	ADJUSTMENTS 6	$\begin{array}{c} \text{NET} \\ \text{EXPENSES FOR} \\ \text{ALLOCATION} \\ \text{(col. 5 ± col. 6)} \\ \hline \end{array}$	
REIMBURSABLE PASS THROUGH COSTS								
47 4700 Allowable GME Costs								47
48 4800 Pneumococcal Vaccines & Med Supplies								48 49
49 4900 Influenza Vaccines & Med Supplies								49
49.10 4910 COVID-19 Vaccines & Med Supplies								49.10
49.11 4911 Monoclonal Antibody Products								49.11
50 Subtotal - Reimbursable Pass through Costs								50
OTHER FQHC SERVICES								
60 6000 Medicare Excluded Services								60
61 6100 Diagnostic & Screening Lab Tests								61
62 6200 Radiology - Diagnostic								62
63 6300 Prosthetic Devices								63
64 6400 Durable Medical Equipment								64
65 6500 Ambulance Services								65
66 6600 Telehealth								66
67 6700 Drugs Charged to Patients								67
68 6800 Chronic Care Management								68
69 6900 Other (Specify)								69
70 Subtotal - Other FQHC Services								70
NONREIMBURSABLE COST CENTERS								
77 7700 Retail Pharmacy								77
78 7800 Nonallowable GME Costs								78
79 7900 Other Nonreimbursable (Specify)								79
80 Subtotal - Non-Reimbursable Costs								80
100 TOTAL (sum of lines 13, 37, 50, 70 and 80)								100

08-16			FORM CMS-224-14					4490 (C	Cont.)
RECLASSIFICA	TIONS			CCN:		PERIOD:		WORKSHEET A	A-1
						FROM:			
			DIOD.			TO:	E A GEG		
			INCRI	LASES		DECF	EASES	1	-
		CODE		LDE #			LDE #		
	EXPLANATION OF RECLASSIFICATION(S)	(1)	COST CENTER	LINE #	AMOUNT	COST CENTER	LINE #	AMOUNT	_
		1	2	3	4	5	6	7	+
									1
2									2
3									3
									_
6									5
7									7
									8
9									9
10									10
11									11
12									11
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
21 22									22
23									23
24									24
25 26									25
26									26
27									27
27 28									28
29 30									29
30									30
31									31
32									32
33									33
34									34
35									35
100 Total reclass	ifications								100

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

Transfer the amounts in columns 4 and 7 to Worksheet A, column 4, lines as appropriate.

FORM CMS-224-14 (04-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4409)

4490	(Cont.)	FORM CMS-224-	14		(08-16
ADJU	JSTMENTS TO EXPENSES	CCN:		PERIOD:	WORKSHEET A-2	
				FROM:		
				TO:		
				EXPENSE CLASSI		
	DESCRIPTION (1)			WORKSHEET A TO	/FROM WHICH	
		BASIS/CODE		THE AMOUNT IS TO) BE ADJUSTED	
		(2)	AMOUNT	COST CENTER	LINE #	<u>.</u>
		1	2	3	4	
1	Investment income - buildings and fixtures (chapter 2)			Buildings and Fixtures	1	1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2	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-2-1				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	1	11
12	Depreciation - movable equipment			Movable Equipment	2	12
13	RCE adjustment to teaching physicians' cost			Allowable GME Costs	47	13
14	Other adjustments (specify) (3)					14
50	TOTAL (sum of lines 1 thru 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 thru 49 and subscripts thereof.

FORM CMS-224-14 (04-2016) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4410)

03-18	FORM CMS-224-14		4490 (Cont.)
STATEMENT OF COSTS OF SERVICES	CCN:	PERIOD:	WORKSHEET A-2-1
FROM RELATED ORGANIZATIONS AND		FROM:	
HOME OFFICE COSTS		TO:	

PART I - COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS

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

* 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 that you furnish the information requested under Part B 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.

				Related C	rganization(s) and/or Ho	ome Office	
			Percentage		Percentage		
	Symbol		of		of	Type of	
	(1)	Name	Ownership	Name	Ownership	Business	
	1	2	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 FQHC.
- B. Corporation, partnership, or other organization has financial interest in FQHC.
- C. FQHC has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of FQHC or relative of such
- person has financial interest in related organization. E. Individual is director, officer, administrator, or key person of FQHC and
- related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in FQHC.
- G. Other (financial or non-financial) specify ____

4490 (Cont.)			FC	RM CMS-224-	-14							03-18
CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS CCN: PERIOD: WOR										WORKSHEET B		
										FROM:		PARTS I & II
										TO:	_	
PART I - CALCULATION OF FEDERALLY QUALIFIED HEALTH C	CENTER COST PER VISIT						_					
							Total	Visits	Title XV	/III Visits	Title XV	'III Costs
	Direct Cost	Total Medical	Other Direct	General								

		Direct Cost	Total Medical	Care Costs &	General									1
		by	& Mental Health	Pharmacy Costs	Service Cost	Total Costs	Average		Mental		Mental		Mental	1
	From Wkst.	Practitioner	Visits	(see	(see	by	Cost Per Visit	Medical Visits	Health Visits	Medical Visits	Health Visits	Medical Cost	Health Cost	1
	A, col. 7,	from Wkst. A	by Practitioner	instructions)	instructions)	Practitioner	by Practitioner							
Positions	line:	1	2	3	4	5	6	7	8	9	10	11	12	
1 Physician	23													1
2 Physician Services Under Agreement	24													2
3 Physician Assistant	25													3
4 Nurse Practitioner	26													4
5 Visiting Registered Nurse	27													5
6 Visiting Licensed Practical Nurse	28													6
7 Certified Nurse Midwife	29													7
8 Clinical Psychologist	30													8
9 Clinical Social Worker	31													9
10 Reg Dietician/Cert DSMT/MNT Educator	33													10
11 Totals														11
12 Unit Cost Multiplier														12
13 Total Cost Per Visit														13

PART II - CALCULATION OF ALLOWABLE DIRECT GRADUATE MEDICAL EDUCATION COSTS						
	Total					
	Cost			Ratio of	Allowable	
	(from Wkst.			Title XVIII	Title XVIII	
	A col. 7,	Total	Title XVIII	Visits to	Direct	
	line 47)	Visits	Visits	Total Visits	GME Costs	
	1	2	3	4	5	
14 Allowable GME Costs						14

44-114

04-21 FORM CM		-14	4490 (Cont			
COMP	PUTATION OF VACCINE COST	CCN:	PERIOD: FROM: TO:		WORKSHEET B-1	
		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES 2	COVID-19 VACCINES 2.01	MONOCLONAL ANTIBODY PRODUCTS 2.02	
1	Health care staff cost (from Worksheet A, column 7, sum of lines 23, and 25 through 36)			2101	2:02	1
2	Ratio of staff time to total health care staff time.					2
3	Total health care staff cost (line 1 x line 2)					3
4	Injections/Infusions and related medical supplies cost (from Worksheet A, column 7, lines 48, 49, 49.10, and 49.11, respectively)					4
5	Direct cost (line 3 + line 4)					5
6	Total direct cost of the FQHC (from Worksheet A, column 7, line 100, minus Worksheet A, column 7, line 8)					6
7	Total administrative overhead (from Worksheet A, column 7, line 8)					7
8	Ratio of direct cost to total direct cost (line 5/line 6)					8
9	Overhead cost (line 7 x line 8)					9
	Total cost of injections/infusions and their administration (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from your records)					11
12	Cost per injection/infusion (line 10 / line 11)					12
13	Number of injections/infusions administered to Original Medicare beneficiaries					13
13.01	Number of COVID-19 injections/infusions administered to MA enrollees					13.01
14	Cost of injections/infusions and their administration costs furnished to Medicare beneficiaries (line 12 times the sum of lines 13 and 13.01, as applicable)					14
	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2,01 and 2,02, line 10)					15
16	Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01 and 2.02, line 14) (transfer this amount to Worksheet E, line 3)					16

4490 (Cont.)	FORM CMS-224-14			04-21
CALCULATION OF REIMBURSEMENT SETTLEMENT	CCN:	PERIOD:	WORKSHEET E	
		FROM:		
		TO:		

1	FQHC PPS Amount	1
2	Direct graduate medical education payments (from Worksheet B, Part II, line 14, column 5)	2
3	Medicare cost of vaccines and their administration (From Worksheet B-1, line 16)	3
4	Medicare advantage supplemental payments (for information only)	4
5	Total (sum of amounts on lines 1 through 3)	5
6	Primary payer payments	6
7	Total amount payable for program beneficiaries (line 5 minus line 6)	7
8	Coinsurance billed to program beneficiaries	8
9	Net Medicare reimbursement excluding bad debts (line 7 minus line 8)	9
10	Allowable bad debts (see instructions)	10
11	Adjusted reimbursable bad debts (see instructions)	11
12	Allowable bad debts for dual eligible beneficiaries (see instructions)	12
13	Subtotal (line 9 plus line 11)	13
13.50	Demonstration payment adjustment amount before sequestration	13.50
14	Other adjustments (specify) (see instructions)	14
15	Amount due FQHC prior to the sequestration adjustment (see instructions)	15
16	Sequestration adjustment (see instructions)	16
16.25	Sequestration for non-claims based amounts (see instructions)	16.25
16.50	Demonstration payment adjustment amount after sequestration	16.50
17	Amount due FQHC after sequestration adjustment (see instructions)	17
18	Interim payments	18
	Tentative settlement (for contractor use only)	19
	Balance due FQHC/program (line 17 minus lines 18 and 19)	20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	21

4-21	FORM CMS-224-14					4490 (Cont.)			
NALYSIS OF PAYMENTS TO THE FEDERALLY QUALI	FIED HEALTH CENTER FOR SERVICES RENDERED	CCN:	FRO	NOD: DM:	WORKSHEET E-	-1			
Description					urt B				
			-		Amount 2	_			
1 Total interim payments paid to FQHC				1	2	1			
2 Interim payments payable on individual bills, either sub- for services rendered in the cost reporting period. If nor						2			
3 List separately each retroactive			.01			3.01			
lump sum adjustment amount based			.02			3.02			
on subsequent revision of the		Program to	.03			3.03			
interim rate for the cost reporting period.		Provider	.04			3.04			
Also show date of each payment.			.05			3.05			
If none, write "NONE" or enter a zero. (1)			.50 .51			3.50 3.51			
		Provider to	.52			3.52			
		Program	.53			3.53			
		riogram	.53			3.54			
Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.5	0-3.98)		.99			3.99			
4 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E, line 18)						4			
TO BE COMPLETED BY CONTRACTOR					1				
5 List separately each tentative settlement		Program to	.01			5.01			
payment after desk review. Also show		Provider	.02 .03			5.02			
date of each payment. If none, write "NONE" or enter a zero. (1)			.03			5.03			
in none, write NONE of enter a zero. (1)		Provider to	.50			5.50			
		Program	.52			5.52			
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50)-5 98)	Intogram	.99			5.99			
6 Determine net settlement amount (balance	, , , , , , , , , , , , , , , , , , , ,	Program to provider	.01			6.01			
due) based on the cost report (1)		Provider to program	.02			6.02			
7 Total Medicare program liability (see instructions)		• • • • • • • • • • • • • • • • • • •				7			
8 Name of Contractor	Contractor Number	NPR Date (mm/dd/yyyy)			8			

(1) On lines 3, 5, and 6, where an amount is due FQHC to program, 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.

	Cont.)	FORM CMS-224-14		DEDIOD	WORKCHEETE 1	04-2
STATEMENT OF REVENUE AND EXPENSES		CCN:		PERIOD From: To:	WORKSHEET F-1	
		Title XVIII	Title XIX	10:		
		Medicare	Medicaid	Other	Total	
	1	1	2	3	4	
1	Gross patient revenues					1
2	Less: Allowances and discounts on patients' accounts			1	2	2
3	Net patient revenues (Line 1 minus line 2)					3
4	Operating expenses (From Worksheet A, column 3, line 100)					4
5	Additions to operating expenses (specify)					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 5 through 9)					10
11	Subtractions from operating expenses (specify)					11
12						12
13						13
4						14
15						15
16	Total subtractions (sum of lines 11 through 15)					16
17	Total operating expenses (sum of line 4, plus line 10, minus line 16)					17
18	Net income from service to patients (line 3 minus line 17)					18
	Other income:					
19	Contributions, donations, bequests, etc.					19
20	Income from investments					20
21	Purchase discounts					21
22	Rebates and refunds of expenses					22
23	Sale of Medical and Nursing Supplies to other than patients					23
24	Sale of durable medical equipment to other than patients					24
25	Sale of drugs to other than patients					25
26	Sale of medical records and abstracts					26
27	Government Appropriations					27
28	Other revenues (specify)					28
28.50	COVID-19 PHE Funding					28.5
29						29
30						30
31						31
32	Total Other Income (sum of lines 19 through 31)					32
33	Net Income or Loss for the period (line 18 plus line 32)					33

FORM CMS-224-14 (04-2021) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4416)