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

FORM APPROVED
OMB NO. 0938-1298
APPROVAL EXPIRES XX-XX-202X

FEDERALLY QUALIFIED HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S PARTS I, II & III

PART I - COST REPORT STATUS

Provider use only	1. [ ] Electronically filed cost report 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report. 4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.	Date:	Time:
Contractor use only	5. [ ] 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. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date:_____ 11. Contractors Vendor Code: _____ 12. [ ] 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 CHIEF FINANCIAL 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
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

PART III - SETTLEMENT SUMMARY

		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 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.

FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET S-1 PART I

PART I - FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

	1	Provider CCN 2	CBSA 3	Date Certified 4	Type of control (see instructions) 5	
1	Site Name:					1
2	Street: P.O. Box:					2
3	City: State: Zip Code: County:	Designation - Enter "R" for rural or "U" for urban:				3
4	Cost Reporting Period (mm/dd/yyyy) From: To:					4
5	Is this FQHC part of an entity that owns, leases or controls multiple FQHCs? 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 FQHC part of a chain organization as defined in §2150 of CMS Pub. 15-1 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

Consolidated Cost Report		1 Y/N	2 Date Requested	3 Date Approved	4 Number of FQHCs	
13	Is this FQHC 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 1	CCN 2	CBSA 3	Date Requested 4	Date Approved 5	
14	List of Consolidated Providers					14
14.01						14.01

FQHC Operations		1	2	3	
15	What type of organization is this FQHC? If you operate as more than one sub-type of an organization enter only the applicable alpha characters in column 2. (see instructions)				15
16	Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the 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. (complete line 17)				16
17	If the response to line 16 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). 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.				17

Medical Malpractice					
18	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? 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.				18
19	Does this FQHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.				19
20	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				20
		Premiums	Paid Losses	Self Insurance	
21	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.				21
22	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than the Administrative and General cost center? Enter "Y" for yes or "N" for no. (see instructions)				22
Interns and Residents					
23	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. -				23
24	Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.				24
25	Did this FQHC receive a Primary Care Residency Expansion (PCRE) 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 primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding and in column 3, enter the total number of visits performed by residents funded by the PCRE grant in this cost reporting period. (see instructions)				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)				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.				27
Contract Labor Cost					
28	Do you use contract labor to provide medical and/or mental health services to your patients? Enter "Y" for yes or "N" for no in column 1.				28

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

PART II - FEDERALLY QUALIFIED HEALTH CENTER CONSOLIDATED COST REPORT PARTICIPANT IDENTIFICATION DATA

	1				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:		Designation - Enter "R" for rural or "U" for urban:				3
	FQHC Operations						1	2	3	
4	What type of organization is this FQHC? If you operate as more than one sub-type of an organization enter only the applicable alpha characters in column 2. (see instructions)									4
5	Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete line 6.									5
6	If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). 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.									6
	Medical Malpractice									
7	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? 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.									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 claims-made or "2" for occurrence policy.									9
							Premiums	Paid Losses	Self Insurance	
10	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.									10
	Interns and Residents									
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.									11
12	Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.									12
13	Did this FQHC receive a Primary Care Residency Expansion (PCRE) 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 primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding and in column 3, enter the total number of visits performed by residents funded by the PCRE grant in this cost reporting period. (see instructions)									13
14	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)									14
	Capital Related Costs - Ownership/Lease of Building									
15	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.									15
	Contract Labor Costs									
16	Do you use contract labor to provide medical and/or mental health services to your patients? Enter "Y" for yes or "N" for no in column 1.									16

FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT QUESTIONNAIRE	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL FQHCs

	Provider Organization and Operation	Y/N 1	Date 2	V/I 3	
1	Has the FQHC 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 FQHC 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 FQHC 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

	Financial Data and Reports	Y/N 1	Type 2	Date 3	Y/N 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 filed financial statements? If yes, submit reconciliation.					4

	Approved Educational Activities	Y/N 1	Y/N 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

	Bad Debts	Y/N 1	
8	Is the FQHC seeking reimbursement for bad debts? If yes, see instructions.		8
9	If line 8 is yes, did the FQHC'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

	PS&R Report Data	Y/N 1	Date 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 FQHC's records for allocation? If column 1 is yes, enter the paid-through date in column 2. (see instructions)			12
13	If line 11or 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.			13
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.			14
15	If line 11 or 12 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: _____			15
16	Was the cost report prepared using only the FQHC's records? If yes, see instructions.			16

Cost Report Preparer Contact Information

17	First name:	Last name:	Title:	17
18	Employer:			18
19	Phone number:	E-mail Address:		19

FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART I

PART I - FEDERALLY QUALIFIED HEALTH CENTER 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

FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART II & III

PART II - FEDERALLY QUALIFIED HEALTH CENTER CONTRACT LABOR AND BENEFIT COST

		Contract Labor	Benefit 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

PART III - FEDERALLY QUALIFIED HEALTH CENTER EMPLOYEE DATA

Enter the number of hours in your normal work week _____		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	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

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET A

		COST CENTER DESCRIPTIONS (omit cents)	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
REIMBURSABLE PASS THROUGH COSTS										
47	4700	Allowable GME Costs								47
48	4800	Pneumococcal Vaccines & Med Supplies								48
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

RECLASSIFICATIONS | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A-1

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			DECREASES			
			COST CENTER	LINE #	AMOUNT	COST CENTER	LINE #	AMOUNT	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
100	Total reclassifications								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.

ADJUSTMENTS TO EXPENSES	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-2

	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	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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-2-1

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 column 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 column 6, line 5 to Worksheet A-2, 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 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 Organization(s) and/or Home Office			
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	Type of 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 _____

CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET B PARTS I & II

PART I - CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COST PER VISIT

									Total Visits		Title XVIII Visits		Title XVIII Costs		
	Positions	From Wkst. A, col. 7, line:	Direct Cost by Practitioner from Wkst. A	Total Medical & Mental Health Visits by Practitioner	Other Direct Care Costs & Pharmacy Costs (see instructions)	General Service Cost (see instructions)	Total Costs by Practitioner	Average Cost Per Visit by Practitioner	Medical Visits by Practitioner	Mental Health Visits by Practitioner	Medical Visits by Practitioner	Mental Health Visits by Practitioner	Medical Cost by Practitioner	Mental Health Cost by Practitioner	
		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 (from Wkst. A col. 7, line 47)	Total Visits	Title XVIII Visits	Ratio of Title XVIII Visits to Total Visits	Allowable Title XVIII Direct GME Costs	
		1	2	3	4	5	
14	Allowable GME Costs						14

COMPUTATION OF VACCINE COST	CCN: _____	PERIOD: FROM: _____ TO: _____		WORKSHEET B-1	
	PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
	1	2	2.01	2.02	
1 Health care staff cost (from Worksheet A, column 7, sum of lines 23, and 25 through 36)					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
10 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
15 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET E

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
19	Tentative settlement (for contractor use only)		19
20	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

ANALYSIS OF PAYMENTS TO THE FEDERALLY QUALIFIED HEALTH CENTER FOR SERVICES RENDERED	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET E-1

	Description				Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to FQHC						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			.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			3.50
				.51			3.51
			Provider to	.52			3.52
			Program	.53			3.53
				.54			3.54
	Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)			.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						
5	List separately each tentative settlement		Program to	.01			5.01
	payment after desk review. Also show		Provider	.02			5.02
	date of each payment.			.03			5.03
	If none, write "NONE" or enter a zero. (1)			.50			5.50
			Provider to	.51			5.51
			Program	.52			5.52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			.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.

STATEMENT OF REVENUE AND EXPENSES		CCN: _____		PERIOD From: _____ To: _____	WORKSHEET F-1	
		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1	2	3	4	
1	Gross patient revenues					1
				1	2	
2	Less: Allowances and discounts on patients' accounts					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
14						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					28.50
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