| ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-1 |
|---|---|---|---|

Check applicable box: [ ] RHC [ ] FQHC

| | | COMPEN-SATION | OTHER COSTS | TOTAL (col. 1 + col. 2) | RECLASS-IFICATIONS | RECLASSIFIED TRIAL BALANCE (col. 3 + col. 4) | ADJUSTMENTS | NET EXPENSES FOR ALLOCATION (col. 5 + col. 6) | |
|---|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| | FACILITY HEALTH CARE STAFF COSTS | | | | | | | | |
| 1 | Physician | | | | | | | | 1 |
| 2 | Physician Assistant | | | | | | | | 2 |
| 3 | Nurse Practitioner | | | | | | | | 3 |
| 4 | Visiting Nurse | | | | | | | | 4 |
| 5 | Other Nurse | | | | | | | | 5 |
| 6 | Clinical Psychologist | | | | | | | | 6 |
| 7 | Clinical Social Worker | | | | | | | | 7 |
| 8 | Laboratory Technician | | | | | | | | 8 |
| 9 | Other Facility Health Care Staff Costs | | | | | | | | 9 |
| 10 | Subtotal (sum of lines 1-9) | | | | | | | | 10 |
| | COSTS UNDER AGREEMENT | | | | | | | | |
| 11 | Physician Services Under Agreement | | | | | | | | 11 |
| 12 | Physician Supervision Under Agreement | | | | | | | | 12 |
| 13 | Other Costs Under Agreement | | | | | | | | 13 |
| 14 | Subtotal (sum of lines 11-13) | | | | | | | | 14 |
| | OTHER HEALTH CARE COSTS | | | | | | | | |
| 15 | Medical Supplies | | | | | | | | 15 |
| 16 | Transportation (Health Care Staff) | | | | | | | | 16 |
| 17 | Depreciation-Medical Equipment | | | | | | | | 17 |
| 18 | Professional Liability Insurance | | | | | | | | 18 |
| 19 | Other Health Care Costs | | | | | | | | 19 |
| 20 | Allowable GME Costs | | | | | | | | 20 |
| 21 | Subtotal (sum of lines 15-20) | | | | | | | | 21 |
| 22 | Total Cost of Health Care Services (sum of lines 10, 14, and 21) | | | | | | | | 22 |
| | COSTS OTHER THAN RHC/FQHC SERVICES | | | | | | | | |
| 23 | Pharmacy | | | | | | | | 23 |
| 24 | Dental | | | | | | | | 24 |
| 25 | Optometry | | | | | | | | 25 |
| 26 | All other nonreimbursable costs | | | | | | | | 26 |
| 27 | Nonallowable GME costs | | | | | | | | 27 |
| 28 | Total Nonreimbursable Costs (sum of lines 23-27) | | | | | | | | 28 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | FACILITY OVERHEAD | | | | | | | | |
| 29 | Facility Costs | | | | | | | | 29 |
| 30 | Administrative Costs | | | | | | | | 30 |
| 31 | Total Facility Overhead (sum of lines 29 and 30) | | | | | | | | 31 |
| 32 | Total facility costs (sum of lines 22, 28 and 31) | | | | | | | | 32 |

The net expenses for cost allocation on Worksheet A for the RHC/FQHC cost center line must equal the total facility costs in column 7, line 32 of this worksheet.

| ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-2 |
|---|---|---|---|

Check applicable box: [ ] RHC [ ] FQHC

**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 | | | | | | 1 |
| 2 | Physician Assistants | | | | | | 2 |
| 3 | Nurse Practitioners | | | | | | 3 |
| 4 | Subtotal (sum of lines 1-3) | | | | | | 4 |
| 5 | Visiting Nurse | | | | | | 5 |
| 6 | Clinical Psychologist | | | | | | 6 |
| 7 | Clinical Social Worker | | | | | | 7 |
| 7.01 | Medical Nutrition Therapist (FQHC only) | | | | | | 7.01 |
| 7.02 | Diabetes Self Management Training (FQHC only) | | | | | | 7.02 |
| 8 | Total FTEs and Visits (sum of lines 4-7) | | | | | | 8 |
| 9 | Physician Services Under Agreements | | | | | | 9 |

**DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES**

| | | | |
|---|---|---|---|
| 10 | Total costs of health care services (from Worksheet M-1, column 7, line 22) | | 10 |
| 11 | Total nonreimbursable costs (from Worksheet M-1, column 7, line 28) | | 11 |
| 12 | Cost of all services (excluding overhead) (sum of lines 10 and 11) | | 12 |
| 13 | Ratio of RHC/FQHC services (line 10 divided by line 12) | | 13 |
| 14 | Total facility overhead (from Worksheet M-1, column 7, line 31) | | 14 |
| 15 | Parent provider overhead allocated to facility (see instructions) | | 15 |
| 16 | Total overhead (sum of lines 14 and 15) | | 16 |
| 17 | Allowable Direct GME overhead (see instructions) | | 17 |
| 18 | Subtract line 17 from line 16 | | 18 |
| 19 | Overhead applicable to RHC/FQHC services (line 13 x line 18) | | 19 |
| 20 | Total allowable cost of RHC/FQHC services (sum of lines 10 and 19) | | 20 |

(1) The productivity standard for physicians is 4,200 and 2,100 for physician assistants and nurse practitioners. If an exception to the standard has been granted (Worksheet S-8, line 12 equals "Y"), column 3, lines 1thru 3 of this worksheet should contain, at a minimum, one element that is different than the standard.

| CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-3 |
|---|---|---|---|

Check applicable boxes: [ ] RHC [ ] FQHC [ ] Title V [ ] Title XVIII [ ] Title XIX

**DETERMINATION OF RATE FOR RHC/FQHC SERVICES**

| | | | |
|---|---|---|---|
| 1 | Total allowable cost of RHC/FQHC services (from Worksheet M-2, line 20) | | 1 |
| 2 | Cost of vaccines and their administration (from Worksheet M-4, line 15) | | 2 |
| 3 | Total allowable cost excluding vaccine (line 1 minus line 2) | | 3 |
| 4 | Total visits (from Worksheet M-2, column 5, line 8) | | 4 |
| 5 | Physicians visits under agreement (from Worksheet M-2, column 5, line 9) | | 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) | | |
|---|---|---|---|---|
| | | Prior to January 1 | On or after January 1 | |
| | | 1 | 2 | |
| 8 | Per visit payment limit (from CMS Pub. *100-04, chapter 9, §20.6* or your contractor) | | | 8 |
| 9 | Rate for Program covered visits (see instructions) | | | 9 |
| **CALCULATION OF SETTLEMENT** | | | | |
| 10 | Program covered visits excluding mental health services (from contractor records) | | | 10 |
| 11 | Program cost excluding costs for mental health services (line 9 x line 10) | | | 11 |
| 12 | Program covered visits for mental health services (from contractor records) | | | 12 |
| 13 | Program covered cost from mental health services (line 9 x line 12) | | | 13 |
| 14 | Limit adjustment for mental health services (see instructions) | | | 14 |
| 15 | Graduate Medical Education pass-through cost (see instructions) | | | 15 |
| 16 | Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) | | | 16 |
| 16.01 | Total program charges (see instructions)(from contractor's records) | | | 16.01 |
| 16.02 | Total program preventive charges (see instructions)(from provider's records) | | | 16.02 |
| 16.03 | Total program preventive costs (see instructions) | | | 16.03 |
| 16.04 | Total program non-preventive costs (see instructions) | | | 16.04 |
| 16.05 | Total program cost (see instructions) | | | 16.05 |
| 17 | Primary payer amounts | | | 17 |
| 18 | Less: Beneficiary deductible for RHC only (see instructions) (from contractor records) | | | 18 |
| 19 | Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records) | | | 19 |
| 20 | Net Medicare cost excluding vaccines (see instructions) | | | 20 |
| 21 | Program cost of vaccines and their administration (from Worksheet M-4, line 16) | | | 21 |
| 22 | Total reimbursable Program cost (line 20 plus line 21) | | | 22 |
| 23 | *Allowable* bad debts (see instructions) | | | 23 |
| *23.01* | *Adjusted reimbursable bad debts (see instructions)* | | | *23.01* |
| 24 | *Allowable* bad debts for dual eligible beneficiaries (see instructions) | | | 24 |
| 25 | Other adjustments (specify) (see instructions) | | | 25 |
| 26 | Net reimbursable amount *(see instructions)* | | | 26 |
| *26.01* | *Sequestration adjustment (see instructions)* | | | *26.01* |
| 27 | Interim payments | | | 27 |
| 28 | Tentative settlement (for contractor use only) | | | 28 |
| 29 | Balance due component/program line 26 minus lines *26.01, 27 and 28* | | | 29 |
| 30 | Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, section 115.2 | | | 30 |

(1) Lines 8 through 14: Fiscal year providers use columns 1 & 2, calendar year providers use column 2 only.

| COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-4 |
|---|---|---|---|

| Check applicable boxes: | [ ] RHC [ ] FQHC | [ ] Title V [ ] Title XVIII | [ ] Title XIX |
|---|---|---|---|

| | | PNEUMOCOCCAL | INFLUENZA | |
|---|---|---|---|---|
| | | 1 | 2 | |
| 1 | Health care staff cost (from Worksheet M-1, column 7, line 10) | | | 1 |
| 2 | Ratio of pneumococcal and influenza vaccine staff time to total health care staff time | | | 2 |
| 3 | Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) | | | 3 |
| 4 | Medical supplies cost - pneumococcal and influenza vaccine (from your records) | | | 4 |
| 5 | Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) | | | 5 |
| 6 | Total direct cost of the facility (from Worksheet M-1, column 7, line 22) | | | 6 |
| 7 | Total overhead (from Worksheet M-2, line 16) | | | 7 |
| 8 | Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) | | | 8 |
| 9 | Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) | | | 9 |
| 10 | Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9) | | | 10 |
| 11 | Total number of pneumococcal and influenza vaccine injections (from your records) | | | 11 |
| 12 | Cost per pneumococcal and influenza vaccine injection (line 10/line 11) | | | 12 |
| 13 | Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries | | | 13 |
| 14 | Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13) | | | 14 |
| 15 | Total cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2) | | | 15 |
| 16 | Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21) | | | 16 |

| ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES | PROVIDER CCN: _____ COMPONENT CCN: _____ | PERIOD: FROM _____ TO _____ | WORKSHEET M-5 |
|---|---|---|---|

Check applicable box: [ ] RHC [ ] FQHC

| | DESCRIPTION | | | Part B 1 mm/dd/yyyy | Part B 2 Amount | |
|---|---|---|---|---|---|---|
| 1 | Total interim payments paid to providers | | | | | 1 |
| 2 | Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter 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 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 |
| | 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 Worksheet M-3, line 27) | | | | | 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 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 |
| | 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 due) based on the cost report (see instructions). (1) | Program to Provider | .01 | | | 6.01 |
| | | Provider to Program | .02 | | | 6.02 |
| 7 | Total Medicare liability (see instructions) | | | | | 7 |
| 8 | Name of Contractor | | | Contractor Number | *NPR* Date (Month/Day/Yea | 8 |

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