

Medicare

Department of Health and
Human Services (DHHS)

Provider Reimbursement Manual Part 2, Provider Cost Reporting Forms and Instructions, Chapter 29, Form CMS-222-92

Centers for Medicare and
Medicaid Services (CMS)

Transmittal 12

DATE: September 18, 2015

<u>HEADER SECTION NUMBERS</u>	<u>PAGES TO INSERT</u>	<u>PAGES TO DELETE</u>
2901 - 2902	29-3 - 29-4 (2 pp.)	29-3 - 29-4 (2 pp.)
2907.2 - 2908.2 (Cont.)	29-9 - 29-11.3 (6 pp.)	29-9 - 29-11.3 (6 pp.)
2910 - 2910 (Cont.)	29-13 - 29-14 (2 pp.)	29-13 - 29-14 (2 pp.)
2990 (Cont.) - 2990 (Cont.)	29-309 - 29-313 (5 pp.)	29-309 - 29-313 (5 pp.)
2995 (Cont.) - 2995 (Cont.)	29-503 - 29-504 (2 pp.)	29-503 - 29-504 (2 pp.)
	29-517 - 29-518.2 (4 pp.)	29-517 - 29-518.2 (4 pp.)
	29-525 - 29-526.2 (4 pp.)	29-525 - 29-526 (2 pp.)

NEW/REVISED MATERIAL--EFFECTIVE: Cost Reporting Periods Beginning on or After October 1, 2014.

For cost reporting periods beginning on or after October 1, 2014, Freestanding Federally Qualified Health Centers (FQHCs), will be required to file using the proposed Freestanding FQHC Cost Report (Form CMS-224-14), not the Independent Rural Health Clinic (RHC)/FQHC Cost Report (Form CMS-222-92).

This transmittal updates Chapter 29, Independent RHC/Freestanding FQHC Cost Report (Form CMS-222-92) to reflect clarifications and corrections to existing instructions. The effective dates for changes vary.

Revisions include:

- Worksheet B, Part II, line 10:
 - Clarified the instructions for the cost of services excluding overhead.
- Worksheet C, line 8:
 - Clarified instructions for RHCs and FQHCs to obtain the maximum per visit rate from the contractor.
- Worksheet C, Part II, line 15.10 and line 18.05:
 - Clarified instructions for appropriate column usage.
- Worksheet B-1:
 - Eliminated columns 2.01 (H1N1 vaccine) and 2.02 (combination influenza and H1N1 vaccines).

REVISED ELECTRONIC SPECIFICATIONS EFFECTIVE DATE: Changes to the electronic reporting specifications are effective for cost reporting periods beginning on or after October 1, 2014.

DISCLAIMER: The revision date and transmittal number apply to the red *italicized material* only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revise information only, and not the entire table of contents.

Pub. 15-2-29

2900. GENERAL

These forms must be used by all independent rural health clinics (RHCs) and freestanding Federally qualified health centers (FQHCs). These forms are required for determining Medicare payment for RHC and FQHC services under 42 CFR 405, Subpart X.

NOTE: For cost reporting periods beginning on or after October 1, 2014, freestanding Federally Qualified Health Centers (FQHCs) cannot file their cost reports using Form CMS-222-92, and will be required to use the proposed Form CMS-224-14.

An RHC/FQHC must complete all applicable items on the worksheets. For its initial reporting period, the facility completes these worksheets with estimates of costs and visits and other information required by the reports. The contractor uses the estimates to determine an interim rate of payment for the facility. Following the end of the facility's reporting period, the facility is required to submit its worksheets using data based on its actual experience for the reporting period. This information is used by the contractor for determining the total Medicare payment due the RHC/FQHC for services furnished Medicare beneficiaries.

2900.1 Rounding Standards for Fractional Computations.--Throughout the Medicare cost report, required computations result in the use of fractions. Use the following rounding standards for such computations:

1. Round to 2 decimal places:
 - a. Rates
 - b. Cost per visit
 - c. Cost for pneumococcal vaccine
2. Round to 6 decimal places:
 - a. Ratios
 - b. Limit adjustments

2901. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-222-92

Part I - General Statistics and Expense Reclassification
and Adjustments

<u>Step No.</u>	<u>Worksheet</u>	<u>Page(s)</u>	
1	S, Part I	1	Read §§2903 and 2903.1. Complete Part I.
2	A	3 & 4	Read §2904. Complete columns 1 through 3, lines 1 through 62.
3	A-1	5	Read §2905. Complete entire worksheet if applicable.
4	A	3 & 4	Read §2904. Complete columns 4 and 5, lines 1 through 62.
5	Supp. A-2-1	6	Read §2909. Complete entire Parts I-III worksheet as applicable.
6	A-2	7	Read §2906. Complete entire worksheet.
7	A	3 & 4	Read §2904. Complete columns 6 and 7, lines 1 through 62.

Part II - Computation of Medicare Cost

<u>Step No.</u>	<u>Worksheet</u>	<u>Page(s)</u>	
1	Supp. B-1	8	Read §2910. Complete if applicable.
2	B, Parts I-II	9	Read §§2907 through 2907.2. Complete entire worksheet.

Part III - Calculation of Reimbursement Settlement

<u>Step No.</u>	<u>Worksheet</u>	<u>Page(s)</u>	
1	C, Parts I-III	10	Read §§2908 through 2908.3. Complete entire worksheet.
2	S, Part II	2	Read §2903.2. Complete certification statement.

2902. SEQUENCE OF ASSEMBLY

The following list of assembly of worksheets is provided so all facilities are consistent in the order of submission of their annual cost report. All facilities using Form CMS-222-92 are to adhere to this sequence. Where worksheets are not completed because they are not applicable, blank worksheets are not included in the assembly of the cost report.

2902.1 Sequence of Assembly - Worksheets.--

<u>Worksheet</u>	<u>Part(s)</u>
S	I & II
A	N/A
A-1	N/A
A-2	N/A
Supp. A-2-1	I, II, & III
B	I & II
B-1	N/A
C	I, II, & III

2903. **WORKSHEET S - INDEPENDENT RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA AND CERTIFICATION STATEMENT**

2903.1 Part I - Statistical Data.--At the top of the worksheet, indicate by checking the appropriate box whether the cost report being filed is a projected or an actual/final cost report.

Column 4.--This is the minimum number of facility visits the personnel in each staff position are expected to furnish. Enter the product of column 1 and column 3.

Column 5.--Enter the greater of the visits from column 2 or column 4. Contractors have the authority to waive the productivity guideline in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor could set any number of visits as reasonable (not just your actual visits) if an exception is granted. For example, if the guideline number is 4200 visits and you have only furnished 1000 visits, the contractor need not accept the 1000 visits but could permit 2500 visits to be used in the calculation.

Line 4.--Enter the total of lines 1 through 3.

Line 8.--Enter the total of lines 4 through 7.

Line 9.--Enter the number of visits furnished to facility patients by physicians under agreement with you who do not furnish services to patients on a regular ongoing basis in the RHC/FQHC facility. Physicians services under agreements with you are (1) all medical services performed at your site by a nonstaff physician who is not the owner or an employee of the facility, and (2) medical services performed at a location other than your site by such a physician for which the physician is compensated by you. While all physician services at your site are included in RHC/FQHC services, physician services furnished in other locations by physicians who are not on your full time staff are paid to you only if your agreement with the physician provides for compensation for such services.

2907.2 Part II - Determination of Total Allowable Cost Applicable To RHC/FQHC Services.--Use Part II to determine the amount of overhead cost applicable to RHC/FQHC services.

Line 10.--Enter the cost of RHC/FQHC services (excluding overhead) from Worksheet A, column 7, line 25 less the amount on Worksheet A, column 7, line **20.50**.

Line 11.--Enter the cost of services (other than RHC/FQHC services) excluding overhead from Worksheet A, column 7, sum of lines 57 and 61.

Line 12.--Enter the cost of all services (excluding overhead). It is the sum of lines 10 and 11.

Line 13.--Enter the percentage of RHC/FQHC services. This percentage is determined by dividing the amount on line 10 (the cost of RHC/FQHC services) by the amount on line 12 (the cost of all services, excluding overhead).

Line 14.--Enter the total overhead costs incurred from Worksheet A, column 7, line 50. It is the sum of facility costs and administrative overhead costs.

Line 14.01.--Enter the amount of GME overhead costs. To determine the amount of GME overhead multiply the amount of facility overhead (from line 14) by the ratio of intern and resident visits (from Worksheet S, Part I, column 3, line 8.50) to total visits (from Worksheet C, Part I, line 6).

Line 14.02.--Enter the net facility overhead costs by subtracting line 14.01 from line 14.

Line 15.--Enter the overhead amount applicable to RHC/FQHC services. Multiply the amount on line 13 (the percentage of RHC/FQHC services) by the amount on line 14 (total overhead). When an amount is entered on line 14.01, enter the result of multiplying the amount on line 13 (the percentage of RHC/FQHC services) by the amount on line 14.02 (net facility overhead).

Line 16.--Enter the total allowable cost of RHC/FQHC services. It is the sum of line 10 (cost of RHC/FQHC services other than overhead services) and line 15 (overhead services applicable to RHC/FQHC services).

2908. WORKSHEET C - DETERMINATION OF MEDICARE PAYMENT

Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment due you for the reporting period.

2908.1 Part I - Determination of Rate For RHC/FQHC Services.--Use Part I to calculate the cost per visit for RHC/FQHC services and to apply the screening guideline established by CMS on your health care staff productivity.

Line 1.--Enter the total allowable cost from Worksheet B, Part II, line 16.

Line 2.--Enter the total cost of pneumococcal and influenza vaccine from Supplemental Worksheet B-1, line 15.

Line 3.--Subtract the amount on line 2 from the amount on line 1 and enter the result.

Line 4.--Enter the greater of the minimum or actual visits by the health care staff from Worksheet B, Part I, column 5, line 8.

Line 5.--Enter the visits made by physicians under agreement from Worksheet B, Part I, column 5, line 9.

Line 6.--Enter the total adjusted visits (sum of lines 4 and 5).

Line 7.--Enter the adjusted cost per visit. This is determined by dividing the amount on line 3 by the visits on line 6.

Lines 8 through 18.--Complete columns 1 and 2 of lines 8 through 18 to identify costs and visits affected by different payment limits during a cost reporting period. For lines 11 through 18, enter in column 3 the sum of columns 1 and 2 (and 2.01, if applicable). Enter the rates and the corresponding data chronologically in the appropriate column as they occur during the cost reporting period. For example, if only one payment limit is applicable during the cost reporting period complete column 1 only. Column 2 can be subscripted to accommodate the possibility of three per visit limits during a cost reporting period.

For services rendered from January 1, 2010, through December 31, 2013, the maximum rate per visit entered on line 8 and the outpatient mental health treatment service limitation applied on line 15 both correspond to the same time period (partial calendar year). Consequently, both are entered in the same column and no further subscripting of the columns are necessary.

Line 8.--Enter the maximum rate per visit that can be received by you. Obtain this amount *from* your contractor.

Line 9.--Enter the lesser of the amount on line 7 or line 8.

2908.2 Part II - Determination of Total Payment.--Use Part II to determine the total Medicare payment due you for covered RHC/FQHC services furnished to Medicare beneficiaries during the reporting period.

Line 10.--Enter the rate for Medicare covered visits from line 9.

Line 11.--Enter the number of Medicare covered visits excluding visits subject to the outpatient mental health services limitation from your contractor records.

Line 12.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 10 by the number of visits on line 11 (the total number of covered Medicare beneficiary visits for RHC/FQHC services during the reporting period).

Line 13.--Enter the number of Medicare covered visits subject to the outpatient mental health services limitation from your contractor records.

Line 14.--Enter the Medicare covered cost for outpatient mental health services by multiplying the rate per visit on line 10 by the number of visits on line 13.

Line 15.--Enter the limit adjustment. In accordance with MIPPA 2008, section 102, the outpatient mental health treatment service limitation applies as follows: For services rendered through December 31, 2009, the limitation is 62.50 percent; services from January 1, 2010, through December 31, 2011, the limitation is 68.75 percent; services from January 1, 2012, through December 31, 2012, the limitation is 75 percent; services from January 1, 2013, through December 31, 2013, the limitation is 81.25 percent; and services on or after January 1, 2014, the limitation is 100 percent. This is computed by multiplying the amount on line 14 by the corresponding outpatient mental health treatment service limit percentage. This limit applies only to therapeutic services not initial diagnostic services.

Line 15.10.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits performed by interns and residents (from Worksheet S, Part I, column 2, line 8.50) by the total intern and resident visits (from Worksheet S, Part I, column 3, line 8.50) and multiply that result by (the sum of the total allowable GME cost reported on Worksheet A, column 7, line 20.50 and allowable GME overhead reported on Worksheet B, Part II, line 14.01). **NOTE:** If Worksheet S, Part I, line 8.50, column 1 is "N", GME pass-through costs on this line must be zero. *For cost reporting periods that overlap January 1, 2011 prorate the result using a ratio of days prior to and on or after January 1, 2011 for each column. For cost reporting periods beginning on or after January 1, 2011, do not use column 1 and enter the result in column 2.*

Line 16.--Enter the total Medicare cost. This is equal to the sum of the amounts on lines 12, 15, and 15.10.

Line 17.--Enter the amount credited to the RHC's Medicare patients to satisfy their deductible liabilities on the visits on lines 11 and 13 as recorded by the contractor from clinic bills processed during the reporting period. RHCs determine this amount from the provider statistical and reimbursement (PS&R) report. FQHCs enter zero on this line as deductibles do not apply.

Line 18.--Enter the net Medicare cost. This is equal to the result of subtracting the amount on line 17 from the amount on line 16. Enter in column 3 the sum of the amounts in columns 1 and 2.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services, effective for dates of service on or after January 1, 2011. RHCs and FQHCs must provide detailed healthcare common procedure coding system (HCPCS) coding for preventive services to ensure coinsurance and deductible are not applied. Providers must maintain this documentation in order to apply the appropriate reductions on lines 18.03 and 18.04. For cost reporting periods that overlap or begin on or after January 1, 2011, providers must complete lines 18.01 through 18.06.

Line 18.01.--Enter the total Medicare charges from the contractor's records (PS&R report). For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter total program charges in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter total program charges in each column, as applicable.

Line 18.02.--Enter the total Medicare preventive charges from the provider's records. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter total program preventive charges in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter total program preventive charges in each column, as applicable.

Line 18.03.--Enter the total Medicare preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter the total program preventive costs ((line 18.02 divided by line 18.01) times line 16)) in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter the total program preventive costs ((line 18.02 divided by line 18.01) times line 16)) in each column, as applicable.

Line 18.04.--Enter the total Medicare non-preventive costs. For cost reporting periods that overlap January 1, 2011, do not complete the column associated with services rendered prior to January 1, 2011, and enter the total program non-preventive costs ((line 18 minus line 18.03) times .80)) in the column associated with services rendered on or after January 1, 2011. For cost reporting periods beginning on or after January 1, 2011, enter the total program non-preventive costs ((line 18 minus line 18.03) times .80)) in each column, as applicable.

Line 18.05.--Enter the net Medicare costs. For cost reporting periods that overlap January 1, 2011, enter total program costs (line 18 times .80) in *the column associated with services rendered prior to January 1, 2011*, and enter the sum of lines 18.03 and 18.04, in *the column associated with services rendered on or after January 1, 2011*, as applicable. For cost reporting periods beginning on or after January 1, 2011, enter the sum of lines 18.03 and 18.04, in each column, as applicable.

Line 18.06.--Enter the coinsurance amount applicable to the RHC or FQHC for program patient visits on lines 11 and 13 as recorded by the contractor from clinic bills processed during the reporting period. This line is captured for informational and statistical purposes only. This line does not impact the settlement calculation.

Line 19.--Enter 80 percent of the amount on line 18, column 3. Do not use this line for cost reporting periods that overlap or begin on or after January 1, 2011.

Line 20.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 20.50.--Enter any other adjustment. Specify the adjustment in the space provided.

Line 21.--Enter the total reimbursable Medicare cost. For cost reporting periods ending before January 1, 2011, enter the sum of the amounts on lines 19 and 20. For cost reporting periods that overlap or begin on or after January 1, 2011, enter the sum of the amounts on lines 18.05, column 3, plus, 20 and 20.50.

Line 22.--Enter the total payments made to you for covered services furnished to Medicare beneficiaries during the reporting period (from contractor records).

Line 23.--This is equal to the result of subtracting the amount on line 22 from the amount on line 21.

Line 24.--Enter your total reimbursable bad debts, net of recoveries, from your records.

Line 24.01.--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. These amounts also are included on line 24. (4/1/2004b)

Line 24.02.--FOR CONTRACTOR USE ONLY--Enter contractor/contractor tentative and final settlements on this line.

Line 24.10.--For cost reporting periods that begin prior to October 1, 2012, enter the amount from line 24. For cost reporting periods that begin on or after October 1, 2012, enter the result of line 24 (including negative amounts) times 88 percent, 76 percent for cost reporting periods that begin on or after October 1, 2013, and 65 percent for cost reporting periods that begin on or after October 1, 2014.

Line 24.11.--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as (2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times the sum of lines 21 and 24.10.

Line 25.--Enter the total amount due to/from the Medicare program (sum of lines 23 and 24.10 minus lines 24.02 and 24.11). This is the amount of the payment reconciliation.

This page is reserved for future use.

Column 3.--Enter the item of service, facility, or supplies which you obtained from the related organization.

Column 4.--Enter the cost to your organization for the service, facility, or supplies which were obtained from the related organization.

Column 5.--Enter the allowable cost of the service, facility, or supplies which were obtained from the related organization. The allowable cost is the lesser of the cost of the service, facility, or supplies to the related organization or the amount a prudent and cost conscious buyer pays for a comparable service, facility or supply purchased elsewhere.

Column 6.--Enter the amount in column 4 minus the amount in column 5. Transfer the(se) amount(s) to the corresponding line of Worksheet A, column 6.

2909.3 Part III - Interrelationship of Facility to Related Organization(s).--Use this part to show your interrelationship to organizations furnishing services, facilities, or supplies to you. The requested data relative to all individuals, partnerships, corporations or other organizations having either a related interest to you, a common ownership with you, or control over you as defined in CMS Pub. 15-1, chapter 10, is shown in columns 1 through 6, as appropriate.

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

Column 1.--Enter the appropriate symbol which describes your interrelationship to the related organization.

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

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

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

Column 5.--If you or the individual indicated in column 2 has a financial interest in the related organization, enter the percent of ownership in such organization.

Column 6.--Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry and linen service.)

2910. SUPPLEMENTAL WORKSHEET B-1 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

Line 1.--Enter the health care staff cost from Worksheet A, column 7, line 12.

Line 2.--Enter the ratio of the estimated percentage of time involved in administering pneumococcal and influenza vaccine injections to the total health care staff time. Do not include physician service under agreement time in this calculation.

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

Line 4.--Enter the cost of pneumococcal and influenza vaccine medical supplies from your records.

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

Line 6.--Enter the amount on Worksheet A, column 7, line 25. This is your total direct cost of the facility.

Line 7.--Enter the amount from Worksheet A, column 7, line 50.

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

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

Line 10.--Enter the sum of the amounts on lines 5 and 9. Transfer this amount to Worksheet C, Part I, line 2.

Line 11.--Enter the total number of pneumococcal and influenza vaccine injections from your records.

Line 12.--Enter the cost per pneumococcal and influenza vaccine injection by dividing the amount on line 10 by the number on line 11 and entering the result.

Line 13.--Enter the number of pneumococcal and influenza vaccine injections from your records.

Line 14.--Enter the cost per pneumococcal and influenza vaccine injection by multiplying the amount on line 12 by the amount on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccine and its (their) administration by entering the sum of the amount in column 1, line 10 and the amount in column 2, line 10. Transfer this amount to Worksheet C, Part I, line 2.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccine and its (their) administration. This is equal to the sum of the amount in column 1, line 14 and column 2, line 14. Transfer the result to Worksheet C, Part II, line 20.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format to be used for electronic cost reporting. Each electronic cost report submission (file) has three types of records. The first group (type one records) contains information for identifying, processing, and resolving problems. The text used throughout the cost report for variable line labels (e.g., Worksheet A) is included in the type two records. Refer to Table 5 for cost center coding. The data detailed in Table 3 are identified as type three records. The encryption coding at the end of the file, records 1, 1.01, and 1.02, are type 4 records.

The medium for transferring cost reports submitted electronically to contractors is a 3½" diskette, compact diskettes (CDs), or a flash drive. These disks must be in IBM format. The character set must be ASCII. You must seek approval from your fiscal intermediary regarding alternate methods of submission to ensure that the method of transmission is acceptable.

The following are requirements for all records:

1. All alpha characters must be in upper case.
2. For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence.
3. No record may exceed 60 characters.

Below is an example of a set of type 1 records with a narrative description of their meaning.

1	2	3	4	5	6
123456789012345678901234567890123456789012345678901234567890					
1	1	213975200909120100904A99P00120101202009274			
1	2	14:30			

Record #1: This is a cost report file submitted by Provider 213975 for the period from April 1, 2009 (2009091) through March 31, 2010 (2010090). It is filed on FORM CMS-222-92. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or approval and is alpha. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the independent rural health clinic facility on April 30, 2010 (2010120). The electronic cost report specification dated October 1, 2009 (2009274) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report file in the following manner:

RFNNNNNN.YYL, where

1. RF (Independent Rural Health Clinic or Federally Qualified Health Center Electronic Cost Report) is constant;
2. NNNNNN is the 6 digit Medicare independent rural health clinic or federally qualified health center provider number;
3. YY is the year in which the provider's cost reporting period ends; and
4. L is a character variable (A-Z) to enable separate identification of files from independent RHC/FQHC facility with two or more cost reporting periods ending in the same calendar year.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		<u>Size</u>	<u>Usage</u>	<u>Loc.</u>	<u>Remarks</u>
1.	Record Type	1	X	1	Constant "1"
2.	NPI	10	9	2-11	Numeric only
3.	Spaces	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	RHC/FQHC Provider Number	6	9	17-22	Field must have 6 numeric characters.
7.	Fiscal Year Beginning Date	7	9	23-29	YYYYDDD - Julian date; first day covered by this cost report
8.	Fiscal Year Ending Date	7	9	30-36	YYYYDDD - Julian date; last day covered by this cost report
9.	MCR Version	1	9	37	Constant "4" (for FORM CMS-222-92)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 32-503.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD – Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD – Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods beginning on or after 2014274 (10/1/2014) . Prior approval(s) 2012275 , 2005090, 2009274 and 2011001.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 222-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
SUPPLEMENTAL WORKSHEET A-2-1 (Continued)				
If type is G, specify description of relationship	1-4	0	36	X
Name of related individual or organization	1-4	2	36	X
Percentage of ownership	1-4	3	6	9 (3).99
Name of related individual or organization	1-4	4	36	X
Percentage of ownership of provider	1-4	5	6	9(3).99
Type of business	1-4	6	15	X
WORKSHEET B-PART I				
Position by department:				
Number of Full Time Equivalent Personnel	1-3,5-7	1	6	9(3).99
Total Visits	1-3,5-7,9	2	11	9
Productivity Standard (see instructions)	1-3	3	11	9
Greater of columns 2 or 4	4	5	11	9
<i>WORKSHEET B-PART II</i>				
<i>Allowable GME Overhead</i>	<i>14.01</i>	<i>1</i>	<i>11</i>	<i>9</i>
<i>Net Facility Overhead Costs</i>	<i>14.02</i>	<i>1</i>	<i>11</i>	<i>9</i>
WORKSHEET C-PART I				
Maximum Rate Per Visit	8	1,2,2.01	6	9(3).99
WORKSHEET C-PART II				
Medicare Covered Visits Excluding Mental Health Services	11	1,2,2.01	11	9
Medicare Covered Visits For Mental Health Services	13	1,2,2.01	11	9
Beneficiary Deductibles	17	1,2,2.01	11	9
Total Program Cost	18	1,2,2.01	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS 222-92
 TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
 DESIGNATIONS

<u>DESCRIPTION</u>	<u>LINE(S)</u>	<u>COLUMN(S)</u>	<u>FIELD SIZE</u>	<u>USAGE</u>
WORKSHEET C-PART II				
Total Program Charges	18.01	1,2,2.01	11	9
Total Program Preventative Charges	18.02	1,2,2.01	11	9
Total Net Program Cost	18.05	1,2,2.01	11	9
Beneficiary Coinsurance	18.06	1,2,2.01	11	9
<i>Other adjustment (specify)</i>	<i>20.50</i>	<i>0</i>	<i>36</i>	<i>X</i>
<i>Other adjustment</i>	<i>20.50</i>	<i>3</i>	<i>11</i>	<i>-9</i>
Payments to RHC/FQHC during Reporting Period	22	3	11	9
Total Reimbursable Bad Debts, Net of Recoveries	24	3	11	-9
Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries	24.01	3	11	9
Adjusted reimbursable bad debts (see instructions)	24.10	3	11	-9
Sequestration adjustment amount	24.11	3	11	9
Total Amount Due To/From The Medicare Program	25	3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN
DESIGNATIONS

SUPPLEMENTAL WORKSHEET B-1

Ratio of Pneumococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time	2	1,2	8	9.9(6)
Medicare supplies cost-Pneumococcal and Influenza Vaccine (From Your Records)	4	1,2	11	9
Total Number of Pneumococcal and Influenza injections (From Provider Records)	11	1,2	11	9
Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries allowable cost	13	1,2	11	9

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B, Part II

TABLE 3B - LINES THAT CANNOT BE SUBSCRIBED
(BEYOND THOSE PREPRINTED)

<u>Worksheet</u>	<u>Lines</u>
S, Part I	1-5,8.50,8.51,9,10,13,14
S, Part III	1-6,9,10
A	1-8,12-14,16-20,20.50,24-33,37- 42,44,49-53,53.50,57,61,62
A-1	ALL
A-2	1-10
A-2-1, Part I	1
A-2-1, Part II	1-3,5
A-2-1, Part III	1-3
B-Part I	1-9
B-Part II	10-14,14.01,14.02,15,16
C, Part I	1-9
C, Part II	10-15,15.10,16-24, 24.01,24.02,24.10,24.11,25 (except 20.50)
B-1	1-16

This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 6 - EDITS

Medicare cost reports submitted electronically must be subjected to various edits, which are divided into two categories: Level I and level II edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software that produces an electronic cost report file for Medicare RHC/FQHCs must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the RHC/FQHC of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file containing a level I edit will be rejected by your fiscal intermediary without exception.

Level I edits (1000 series reject codes) test that the file conforms to processing specifications, identifying error conditions that would result in a cost report rejection. These edits also test for the presence of some critical data elements specified in Table 3. Level II edits (2000 series edit codes) identify potential inconsistencies and/or missing data items that may have exceptions and should not automatically cause a cost report rejection. Resolve these items and submit appropriate worksheets and/or data supporting the exceptions with the cost report. Failure to submit the appropriate data with your cost report may result in payments being withheld pending resolution of the issue(s).

The vendor requirements (above) and the edits (below) reduce both intermediary processing time and unnecessary rejections. Vendors should develop their programs to prevent their client RHC/FQHCs from generating either a hard copy substitute cost report or electronic cost report file where level I edits exist. Ample warnings should be given to the provider where level II edit conditions are violated.

NOTE: Dates in brackets [] at the end of an edit indicate the effective date of that edit for cost reporting periods ending on or after that date. Dates followed by a "b" are for cost reporting periods beginning on or after the specified date. Dates followed by an "s" are for services rendered on or after the specified date unless otherwise noted.
[3/31/2005]

I. Level I Edits (Minimum File Requirements)

<u>Reject Code</u>	<u>Condition</u>
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [3/31/2005]
1005	No record may exceed 60 characters. [3/31/2005]
1010	All alpha characters must be in upper case. This is exclusive of the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [3/31/2005]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [3/31/2005]
1020	The independent RHC/FQHC facility provider number (record #1, positions 17-22) must be valid and numeric (issued by the applicable certifying agency and falls within the specified range). [3/31/2005]
1025	All dates (record #1, positions 23-29, 30-36, 45-51, and 52-58) must be in Julian format and legitimate. [3/31/2005]
1030	The fiscal year beginning date (record #1, positions 23-29) must be less than the fiscal year ending date (record #1, positions 30-36). [3/31/2005]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 6 – EDITS

<u>Reject Code</u>	<u>Condition</u>
1035	The vendor code (record #1, positions 38-40) must be a valid code. [3/31/2005]
1050	The type 1 record #1 must be correct and the first record in the file. [3/31/2005]
1055	All record identifiers (positions 1-20) must be unique. [3/31/2005]
1060	Only a Y or N is valid for fields which require a Yes/No response. [3/31/2005]
1075	Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [3/31/2005]
1080	For every line used on Worksheet A, there must be a corresponding type 2 record. [3/31/2005]
1090	Fields requiring numeric data (charges, treatments, costs, FTEs, etc.) may not contain any alpha character. [3/31/2005]
1100	In all cases where the file includes both a total and the parts that comprise that total, each total must equal the sum of its parts. [3/31/2005]
1005S	The cost report ending date (Worksheet S, Part I, column 2, line 4) must be on or after March 31, 2005. [3/31/2005]
1015S	The cost report period beginning date (Worksheet S, Part I, column 1, line 4) must precede the cost report ending date (Worksheet S, Part I, column 2, line 4). [3/31/2005]
1020S	The independent RHC/FQHC facility name, address, provider number, and certification date (Worksheet S, line 1, column 1 (name); line 1.01, column 1 (street address); line 1.02, columns 1 (city), 2 (State), and 3 (ZIP code); line 1.03, column 1 (county); line 2, column 1 (provider number); and line 5, column 4 (certification date), respectively) must be present and valid. [3/31/2005]
<i>1021S</i>	<i>If Worksheet S, Part I, line 5, column 3, is “2” (indicating an FQHC), then Worksheet S, Part I, line 4, column 1, cannot be on or after October 1, 2014. [10/01/2014b]</i>
1025S	If the response to Worksheet S, Part I, line 14, column 1, is “Y”, then the facility name, address, provider number, designation (applicable for FQHCs only, (Worksheet S, Part I, line 5, column 3, is “2”)), and certification date (Worksheet S, Part III, line 1, column 1; line 2, column 1; line 3, columns 1, 2, and 3; line 4, column 1; line 5, column 1; and line 6, columns 1 and 2, respectively) must be present and valid. [3/31/2005]
1030S	If the response to Worksheet S, Part I, line 14, column 1, is “Y”, then Worksheet S, Part I, line 14, column 2, must be greater than 0 (zero), but if Worksheet S, Part I, line 14, column 1, is “N”, then Worksheet S, Part I, line 14, column 2, must equal 0 (zero). Additionally, if line 14, column 2, is greater than zero, this number must reflect the number of consolidated facilities (Worksheet S, Part III), excluding the main provider. [12/31/2006]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-92
TABLE 6 – EDITS

<u>Reject Code</u>	<u>Condition</u>
<i>1031S</i>	<i>For cost reports that overlap October 1, 2014, and where Worksheet S, Part I, line 5, column 3, is “2” (indicating an FQHC), then Worksheet S, Part III, line 6, column 2, cannot be on or after October 1, 2014. [10/01/2014b]</i>
1000A	All amounts reported on Worksheet A, columns 1-2, line 62, must be greater than or equal to zero. [3/31/2005]
1020A	For reclassifications reported on Worksheet A-1 the sum of all increases (column 4) must equal the sum of all decreases (column 7). [3/31/2005]

This page is reserved for future use.

INDEPENDENT RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT		PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET S PART I (Cont.) & PART II
PART I (CONT.)-STATISTICAL DATA				
9 Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.				9
10 If line 9 is "Y", specify type of operation. (i.e., physicians office, independent laboratory, etc.)				10
11 Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day				11
	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07
12 Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.				12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07
13 If this is a low or no Medicare Utilization cost report, enter "L" for low or "N" for no Medicare utilization.				13
14 Is this facility filing a consolidated cost report under CMS Pub. 100-4, chapter 9, section 30.8? Enter "Y" for yes or "N" for no. If yes, see instructions.				14

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR

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

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 and Number) for the cost report 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 the cost report were provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Facility	Title	Date
--------------------------------------	-------	------

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 to average 50 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.

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING
FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET
STATISTICAL DATA AND CERTIFICATION STATEMENT

PROVIDER CCN:

PERIOD:

WORKSHEET S

CLINIC CCN:

FROM:

PART III

TO:

PART III - STATISTICAL DATA FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING

1	Name:			1
2	Street:		P.O. Box:	2
3	City:	State:	Zip Code:	3
4	County:			4
5	Provider Number:			5
6	Designation:		Date Certified:	6
7	Names of physicians furnishing services at the health facility or under agreement (as described in instructions) and Medicare billing numbers (include all Part B billing numbers)			7
	Name		Billing Number	
	1		2	
7.01				7.01
7.02				7.02
7.03				7.03
7.04				7.04
7.05				7.05
8	Supervisory Physicians			8
	Name		Hours of Supervision For Reporting Period	
	1		2	
8.01				8.01
8.02				8.02
8.03				8.03
8.04				8.04
8.05				8.05
9	Does the facility operate as other than a RHC or FQHC? Enter "Y" for yes or "N" for no.			9
10	If yes, specify what type of operation. (i.e., physicians office, independent laboratory, etc.)			10
11	Identify days and hours by listing the time the facility operates as a RHC or FQHC next to the applicable day			11
	Days	Hours of Operation		
		From	To	
11.01	Sunday			11.01
11.02	Monday			11.02
11.03	Tuesday			11.03
11.04	Wednesday			11.04
11.05	Thursday			11.05
11.06	Friday			11.06
11.07	Saturday			11.07
12	Identify days and hours by listing the time the facility operates as other than a RHC or FQHC next to the applicable day.			12
	Days	Hours of Operation		
		From	To	
12.01	Sunday			12.01
12.02	Monday			12.02
12.03	Tuesday			12.03
12.04	Wednesday			12.04
12.05	Thursday			12.05
12.06	Friday			12.06
12.07	Saturday			12.07

FORM CMS-222-92 (01-2005) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 2903.2)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES			PROVIDER CCN:		PERIOD: FROM: TO:		WORKSHEET A Page 1		
COST CENTER			Compen- sation	Other	Total (Col. 1 + 2)	Reclassi- fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)
			1	2	3	4	5	6	7
FACILITY HEALTH CARE STAFF COSTS									
1	0100	Physician							1
2	0200	Physician Assistant							2
3	0300	Nurse Practitioner							3
4	0400	Visiting Nurse							4
5	0500	Other Nurse							5
6	0600	Clinical Psychologist							6
7	0700	Clinical Social Worker							7
8	0800	Laboratory Technician							8
9	0900	Other (Specify)							9
10	1000								10
11	1100								11
12		Subtotal-Facility Health Care Staff Costs							12
COSTS UNDER AGREEMENT									
13	1300	Physician Services Under Agreement							13
14	1400	Physician Supervision Under Agreement							14
15	1500								15
16		Subtotal Under Agreement (Lines 13-15)							16
OTHER HEALTH CARE COSTS									
17	1700	Medical Supplies							17
18	1800	Transportation (Health Care Staff)							18
19	1900	Depreciation-Medical Equipment							19
20	2000	Professional Liability Insurance							20
20.50	2050	Allowable GME Pass Through Costs							20.50
21	2100	Other (Specify)							21
22	2200								22
23	2300								23
24		Subtotal-Other Health Care Costs (Lines 17-23)							24
25		Total Cost of Services (Other Than Overhead And Other RHC/FQHC Services) Sum of Lines 12, 16, And 24							25
FACILITY OVERHEAD-FACILITY COST									
26	2600	Rent							26
27	2700	Insurance							27
28	2800	Interest On Mortgage Or Loans							28
29	2900	Utilities							29

FORM CMS-222-92 (05-2013) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 2904)

RECLASSIFICATIONS		PROVIDER CCN:		PERIOD: FROM: TO:		WORKSHEET A-1		
EXPLANATION OF ENTRY	CODE	INCREASE			DECREASE			
	(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
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
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)							36

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

(2) Transfer to Worksheet A, Col 4, line as appropriate.

FORM CMS-222-92 (03-1993) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 2905)

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	PROVIDER CCN:	PERIOD: FROM: TO:			WORKSHEET B PARTS I & II
PART I - VISITS AND PRODUCTIVITY	Part A - Visits And Productivity				
	1	2	3	4	5
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. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Subtotal (Sum of lines 1-3)					
5. Visiting Nurse					
6. Clinical Psychologist					
7. Clinical Social Worker					
7.01. Medical Nutrition Therapist (FQHC only)					
7.02. Diabetes Self Management Training (FQHC only)					
8. Total Staff					
9. Physician Services Under Agreement					

(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, *Part I*, line 8.51 equals "Y"), input in col. 3, lines 1 through 3, the productivity standards derived by the contractor.

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

	Amount
10. Cost of RHC/FQHC Services - excluding overhead - (Wkst. A, col. 7, line 25 minus <i>Wkst. A</i> , col. 7, line <i>20.50</i>)	
11. Cost of Other Than RHC/FQHC Services - Excluding overhead (W/S <i>A</i> , col. 7, sum of <i>lines 57 and 61</i>)	
12. Cost of All Services - excluding overhead - (sum of <i>lines 10 and 11</i>)	
13. Ratio of RHC/FQHC Services (<i>line 10</i> divided by <i>line 12</i>)	
14. Total Overhead - (<i>Wkst. A</i> , col. 7, line 50)	
14.01. Allowable GME Overhead (see instructions)	
14.02. Net Facility Overhead Costs	
15. Overhead Applicable to RHC/FQHC Services (see instructions)	
16. Total Allowable Cost of RHC/FQHC Services (sum of lines 10 and 15)	

FORM CMS-222-92 (09-2015) INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2 SECTIONS 2907 THROUGH 2907.2)

DETERMINATION OF MEDICARE PAYMENT	PROVIDER CCN:	PERIOD: FROM: TO:	WORKSHEET C PART I
-----------------------------------	---------------	-------------------------	-----------------------

PART I- DETERMINATION OF RATE FOR RHC/FQHC SERVICES				AMOUNT	
1	Total Allowable Costs (Worksheet B, Part II, <i>line 16</i>)				1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (<i>from Supplemental Worksheet B-1, line 15</i>)				2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (<i>line 1 - line 2</i>)				3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part 1, <i>column 5, line 8</i>)				4
5	Physicians Visits Under Agreements (Worksheet B, Part 1, <i>column 5, line 9</i>)				5
6	Total Adjusted Visits (<i>line 4 + line 5</i>)				6
7	Adjusted Cost Per Visit (<i>line 3 divided by line 6</i>)				7
		1	2	2.01	3
		Rate Period 1	Rate Period 2	Rate Period 3	
8	Maximum Rate Per Visit (<i>see instructions</i>)				8
9	Rate For Medicare Covered Visits (<i>lessor of line 7 or line 8</i>)				9

FORM CMS-222-92 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 2908 AND 2908.1)

DETERMINATION OF MEDICARE PAYMENT		PROVIDER CCN:	PERIOD: FROM: TO:		WORKSHEET C PART II
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	2.01	3
		Rate period 1	Rate Period 2	Rate Period 3	
10	Rate for Medicare Covered Visits (<i>from Worksheet C, Part I, line 9</i>)				10
11	Medicare Covered Visits Excluding Mental Health Services (<i>from contractor records</i>)				11
12	Medicare Cost Excluding Costs for Mental Health Services (<i>line 10 multiplied by line 11</i>)				12
13	Medicare Covered Visits for Mental Health Services (<i>from contractor records</i>)				13
14	Medicare Covered Cost for Mental Health Services (<i>line 10 multiplied by line 13</i>)				14
15	Limit Adjustment (<i>line 14 times the applicable percentage</i>) (see instructions)				15
15.10	Graduate Medical Education Pass Through Cost (see instructions)				15.10
16	Total Medicare Cost (<i>line 12 plus line 15 plus line 15.10</i>)				16
17	Less: Beneficiary Deductible for RHC only (see instructions) (<i>from contractor records</i>)				17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (see instructions)				18
18.01	Total Medicare charges (see instructions)(<i>from contractor's records (PS&R Report)</i>)				18.01
18.02	Total Medicare preventive charges (see instructions)(<i>from provider's records</i>)				18.02
18.03	Total Medicare preventive costs ((<i>line 18.02/line 18.01</i>) times line 16)				18.03
18.04	Total Medicare non-preventive costs ((<i>line 18 minus line 18.03</i>) times 80%)				18.04
18.05	Net Medicare cost (see instructions)				18.05
18.06	<i>Beneficiary coinsurance for RHC/FQHC services</i> (see instructions) (<i>from contractor records</i>)				18.06
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (see instructions)				19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (<i>from Supp. Worksheet B-1, line 16</i>)				20
20.50	Other adjustments (specify)				20.50
21	Total Reimbursable Medicare Cost (see instructions)				21
22	Less Payments to RHC/FQHC During Reporting Period				22
23	Balance Due To/From The Medicare Program Exclusive of Bad Debts (<i>line 21 less line 22</i>)				23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (<i>from provider records</i>)				24
24.01	Total Gross Reimbursable Bad Debts for Dual Eligible Beneficiaries (<i>from provider records</i>)				24.01
24.02	Tentative settlement (for contractor use only)				24.02
24.10	Adjusted reimbursable bad debts (see instructions)				24.10
24.11	Sequestration adjustment (see instructions)				24.11
25	Total Amount Due To/From The Medicare Program (see instructions)				25

FORM CMS-222-92 (09-2015) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTIONS 2908 AND 2908.2)

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I - III
---	---------------	-------------------------	--

Part I. Introduction. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?
 Yes No (If "Yes", complete Parts II and III)

Part II. Costs incurred and adjustments required (as result of transactions with related organizations):

LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL.4 MINUS COL. 5)	
Line No.	Cost Center	Expense Items	AMOUNT			
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 1-4 to Wkst. A, col. 6 as appropriate) (Transfer col.6, line 5 to Wkst. A-2, col. 2, line 6, Adjustment to Expenses)					5

Part III. Interrelationship of facility to related organization (s):

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 III of this worksheet.

This information is used by the Centers for Medicare & Medicaid Services and its intermediaries 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 the provider does 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	Percentage of Ownership	RELATED ORGANIZATION (S)			
			Name	Percentage of Ownership	Type of Business	
1	2	3	4	5	6	
1						1
2						2
3						3
4						4

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

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		PROVIDER CCN:	PERIOD: FROM: TO:	SUPPLEMENTAL WORKSHEET B-1	
			1	2	
PART 1 - CALCULATION OF COST			PNEUMOCOCCAL	SEASONAL INFLUENZA	
1	Health Care Staff Cost (Worksheet A, <i>c</i> olumn 7, <i>l</i> ine 12)				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 (<i>l</i> ine 1 x <i>l</i> ine 2)				3
4	Medical Supplies Cost - Pneumococcal and Influenza Vaccine (<i>f</i> rom <i>y</i> our <i>r</i> ecords)				4
5	Direct Cost of Pneumococcal and Influenza Vaccine (<i>s</i> um of <i>l</i> ines 3 & 4)				5
6	Total Direct Cost of the Facility (Worksheet A, <i>c</i> olumn 7, <i>l</i> ine 25)				6
7	Total Facility Overhead (Worksheet A, <i>c</i> olumn 7, <i>l</i> ine 50)				7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (<i>l</i> ine 5 divided by <i>l</i> ine 6)				8
9	Overhead Cost - Pneumococcal and Influenza Vaccine (<i>l</i> ine 7 x <i>l</i> ine 8)				9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of <i>l</i> ines 5 & 9)				10
11	Total Number of Pneumococcal and Influenza Vaccine Injections (<i>f</i> rom <i>p</i> rovider <i>r</i> ecords)				11
12	Cost Per Pneumococcal and Influenza Vaccine Injection (<i>l</i> ine 10 divided by <i>l</i> ine 11)				12
13	Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicare Beneficiaries				13
14	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (<i>l</i> ine 12 <i>m</i> ultiplied by <i>l</i> ine 13)				14
15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (<i>s</i> um of <i>l</i> ine 10, <i>c</i> olumns 1 and 2) Transfer to Wkst. C, Part I, <i>l</i> ine 2				15
16	Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (<i>s</i> um of <i>l</i> ine 14, <i>c</i> olumns 1 and 2) Transfer to Wkst. C, Part II, <i>l</i> ine 20				16