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

FORM APPROVED
OMB NO: 0938-0107
EXPIRATION DATE 05/31/2025

RURAL HEALTH CLINIC 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 prepared cost report — Date: — Time:
2. [ ] Manually prepared 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, "N" for no utilization, *or "V" for vaccines only*.

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 BY A CHIEF FINANCIAL 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 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	RHC		1

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

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

PART I - RURAL HEALTH CLINIC 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:		3
4	Cost Reporting Period (mm/dd/yyyy) From:	To:				4
5	Is this RHC part of an entity that owns, leases or controls multiple RHCs? Enter "Y" for yes or "N" for no. If yes, enter the entity's information below.					5
6	Name of Entity:					6
7	Street:	P.O. Box:				7
8	City:	State:	Zip Code:			8
9	Is this RHC part of a chain organization as defined in §2150 of CMS Pub. 15, Part 1 that claims home office costs in a Home Office Cost Statement? Enter "Y" for yes or "N" for no in column 1. If yes, enter the chain organization's information below.					9
10	Name of Chain Organization:					10
11	Street:	P.O. Box:	Home Office CCN:			11
12	City:	State:	Zip Code:			12

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

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

Medical Malpractice

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

Miscellaneous

19	Is this RHC and/or any consolidated RHCs involved in training residents in an approved GME program in accordance with 42 CFR 405.2468(f)? Enter "Y" for yes or "N" for no. (see instructions)				19
20	Have you received an approval for an exception to the productivity standard?				20
21	Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.				21
22	If line 21 is "Y", specify type of operation. (i.e. physicians office, independent laboratory, etc.)				22
23	Identify days and hours by listing the time the facility operates as a RHC next to the applicable day.				23

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

		Hours of Operation		
24	Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day.			24
		From	To	
	Days	1	2	
24.01	Sunday			24.01
24.02	Monday			24.02
24.03	Tuesday			24.03
24.04	Wednesday			24.04
24.05	Thursday			24.05
24.06	Friday			24.06
24.07	Saturday			24.07

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

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

PART II - RURAL HEALTH CLINIC CONSOLIDATED COST REPORT 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:			3
Medical Malpractice						1	
4	Does this RHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.						4
5	If line 4 is yes, is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.						5
				Premiums 1	Paid Losses 2	Self Insurance 3	
6	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.						6
Miscellaneous							
7	Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.						7
8	If line 7 is "Y", specify type of operation. (i.e. physicians office, independent laboratory, etc.)						8
9	Identify days and hours by listing the time the facility operates as a RHC next to the applicable day.						9

	Days	Hours of Operation From 1	To 2	
9.01	Sunday			9.01
9.02	Monday			9.02
9.03	Tuesday			9.03
9.04	Wednesday			9.04
9.05	Thursday			9.05
9.06	Friday			9.06
9.07	Saturday			9.07
10	Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day.			10

	Days	Hours of Operation From 1	To 2	
10.01	Sunday			10.01
10.02	Monday			10.02
10.03	Tuesday			10.03
10.04	Wednesday			10.04
10.05	Thursday			10.05
10.06	Friday			10.06
10.07	Saturday			10.07

FORM CMS-222-17 (05-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4604.2)

RURAL HEALTH CLINIC REIMBURSEMENT QUESTIONNAIRE	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2

COMPLETED BY ALL RHCs

	Provider Organization and Operation	Y/N 1	Date 2	V/I 3	
1	Has the RHC changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)				1
2	Has the RHC terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. (see instructions)				2
3	Is the RHC involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

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

	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 RHCs 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 only using the RHC'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

RURAL HEALTH CLINIC DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3

RURAL HEALTH CLINIC STATISTICAL DATA

		CENTER CCN	Title V	Title XVIII	Title XIX	Other	Total All Patients	
		0	1	2	3	4	5	
1	Medical Visits							1
2	Total Medical Visits							2
3	Mental Health Visits							3
4	Total Mental Health Visits							4
5	Number of Visits Performed by Interns and Residents							5
6	Total Number of Visits Performed by Interns and Residents							6
7	Total Visits (sum of lines 2 and 4)							7

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

		COST CENTER	SALARIES	OTHER	TOTAL	RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION	
			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	Certified Nurse Midwife								4
5	0500	Registered Nurse								5
6	0600	Licensed Practical Nurse								6
7	0700	Clinical Psychologist								7
8	0800	Clinical Social Worker								8
9	0900	Laboratory Technician								9
10	1000	Other (specify)								10
14		Subtotal-Facility Health Care Staff Costs (sum of lines 1 through 10)								14
COSTS UNDER AGREEMENT										
15	1500	Physician Services Under Agreement								15
16	1600	Physician Supervision Under Agreement								16
17		Subtotal Under Agreement (sum of lines 15 and 16)								17
OTHER HEALTH CARE COSTS										
25	2500	Medical Supplies								25
26	2600	Transportation (Health Care Staff)								26
27	2700	Depreciation-Medical Equipment								27
28	2800	Malpractice Premiums								28
29	2900	Allowable GME Costs								29
30	3000	Pneumococcal Vaccines & Med Supplies								30
31	3100	Influenza Vaccine & Med Supplies								31
31.10	3110	COVID-19 Vaccine & Med Supplies								31.10
31.11	3111	Monoclonal Antibody Products								31.11
32	3200	Other (specify)								32
38		Subtotal-Other Health Care Costs (sum of lines 25 through 32)								38
39		Total Cost of Services (Other Than Overhead And Other RHC Services) (sum of lines 14, 17, and 38)								39
FACILITY OVERHEAD-FACILITY COST										
40	4000	Rent								40
41	4100	Insurance								41
42	4200	Interest On Mortgage Or Loans								42
43	4300	Utilities								43
44	4400	Depreciation-Buildings And Fixtures								44
45	4500	Depreciation-Movable Equipment								45
46	4600	Housekeeping And Maintenance								46
47	4700	Property Tax								47
48	4800	Other (specify)								48
59		Subtotal-Facility Costs (sum of lines 40 through 48)								59

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

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

RECLASSIFICATIONS | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A-6

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

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

ADJUSTMENTS TO EXPENSES	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8

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

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 14 through 49 and subscripts thereof.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET A-8-1

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

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

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

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

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

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

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

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

PART I - VISITS AND PRODUCTIVITY

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

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

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

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

COMPUTATION OF 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, line 14)					1
2	Ratio of injection/infusion staff time to total health care staff time					2
3	Injection/infusion health care staff cost (line 1 multiplied by line 2)					3
4	Injections/infusions and related medical supplies cost (from Worksheet A, column 7, lines 30, 31, 31.10, and 31.11, respectively)					4
5	Direct cost of injections/infusions (sum of lines 3 and 4)					5
6	Total direct cost of the RHC (from Worksheet A, column 7, line 39)					6
7	Total facility overhead (from Worksheet A, column 7, line 74)					7
8	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)					8
9	Overhead cost - injections/infusions (line 7 multiplied by line 8)					9
10	Total injection/infusion cost and administration (sum of lines 5 and 9)					10
11	Total number of injections/infusions (from provider records)					11
12	Cost per injection/infusion (line 10 divided by line 11)					12
13	Number of injections/infusions administered to Medicare beneficiaries					13
13.01	Number of COVID-19 injections/infusions administered to MA enrollees					13.01
14	Medicare cost of injections/infusions and administration (line 12 multiplied by the sum of lines 13 and 13.01, as applicable)					14
15	Total cost of injections/infusions and administration (sum of columns 1, 2, 2.01, and 2.02, line 10) Transfer to Worksheet C, Part I, line 2					15
16	Total Medicare cost of injections/infusions and administration (sum of columns 1, 2, 2.01, and 2.02, line 14) Transfer to Worksheet C, Part II, line 23					16

DETERMINATION OF MEDICARE PAYMENT	CCN:	PERIOD: FROM: TO:	WORKSHEET C PARTS I & II

	PART I- DETERMINATION OF RATE FOR RHC SERVICES	AMOUNT	
1	Total allowable costs (Worksheet B, Part II, line 18)		1
2	Cost of injections/infusions and administration (from Worksheet B-1, line 15)		2
3	Total allowable cost excluding injections/infusions (line 1 minus line 2)		3
4	Greater of minimum visits or actual visits by health care staff (from Worksheet B, Part I, column 5, line 10)		4
5	Physicians visits under agreements (from Worksheet B, Part I, column 5, line 11)		5
6	Total adjusted visits (line 4 plus line 5)		6
7	Adjusted cost per visit (line 3 divided by line 6)		7

		Calculation of Limit (1)			
		Payment Limit Period 1	Payment Limit Period 2	Payment Limit Period 3	
8	Maximum rate per visit (see instructions)				8
9	Rate for Medicare covered visits (lesser of line 7 or line 8)				9

	PART II - DETERMINATION OF TOTAL PAYMENT	Payment Limit Period 1	Payment Limit Period 2	Payment Limit Period 3	
10	Medicare covered visits excluding mental health services (from contractor records)				10
11	Medicare cost excluding costs for mental health services (line 9 multiplied by line 10)				11
12	Medicare covered visits for mental health services (from contractor records)				12
13	Medicare covered cost for mental health services (line 9 multiplied by line 12)				13
14	Total Medicare cost (line 11 plus line 13)				14
15	Less: Medicare beneficiary deductible (see instructions)				15
16	Net Medicare cost excluding injections/infusions and administration (line 14 minus line 15)				16
17	Total Medicare charges (see instructions)				17
18	Total Medicare preventive charges (see instructions)				18
19	Total Medicare preventive costs ((line 18 divided by line 17) times line 14)				19
20	Total Medicare non-preventive costs ((line 16 minus line 19) times 80 percent)				20
21	Net Medicare cost (line 19 plus 20) (see instructions)				21
22	Graduate medical education pass through cost (see instructions)				22
23	Medicare cost of injections/infusions and administration (from Worksheet B-1, line 16)				23
24	Primary payer payments				24
25	Net Medicare reimbursement excluding bad debts (see instructions)				25
26	Allowable bad debts (see instructions)				26
27	Adjusted reimbursable bad debts (see instructions)				27
28	Allowable bad debts for dual eligible beneficiaries (see instructions)				28
29	Subtotal (line 25 plus line 27)				29
30	Other demonstration payment adjustment amount before sequestration				30
31	Other adjustments (specify) (see instructions)				31
32	Amount due RHC prior to sequestration adjustment (line 29 minus lines 30 and 31)				32
33	Sequestration adjustment (see instructions)				33
34	Other demonstration payment adjustment amount after sequestration				34
35	Amount due RHC after sequestration adjustment (line 32 minus lines 33 and 34)				35
36	Interim payments				36
37	Tentative settlement (for contractor use only)				37
38	Balance due RHC/program (line 35 minus lines 36 and 37)				38
39	Protested amounts (nonallowable cost report items) in accordance with 42 CFR 413.24(j)(2)(i)				39

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

ANALYSIS OF PAYMENTS TO THE RURAL HEALTH CLINIC FOR SERVICES RENDERED	CCN:	PERIOD: FROM: _____ TO: _____	WORKSHEET C-1

	Description			Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to RHC					1
2	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2
3	List separately each retroactive		.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. C, Part II, line 36)					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 RHC to program, show the amount and date on which the RHC agrees to the amount of repayment even though total repayment is not accomplished until a later date.