Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 46, Form CMS-222-17

Department of Health and Human Services (DHHS)
Centers for Medicare and Medicaid Services (CMS)

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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents Chapter 46	46-1 (1 pp.)	-----
4600 - 4614(Cont.)	46-3 - 46-38 (36 pp.)	-----
4690 - 4690 (Cont.)	46-301 - 46-316 (16 pp.)	-----
4695 - 4695 (Cont.)	46-501 - 46-540 (40 pp.)	-----

NEW MATERIAL--EFFECTIVE DATE*:* Cost Reporting Periods Ending on or After September 30, 2018.

This transmittal introduces Chapter 46, Rural Health Clinic (RHC) Cost Report, Form CMS-222-17, effective for cost reporting periods ending on or after September 30, 2018. These new instructions and forms must be filed by freestanding RHCs and RHCs previously reported as part of a Skilled Nursing Facility (SNF) complex or Home Health Agency (HHA) complex. RHCs that are part of a hospital healthcare complex must use the Form CMS-2552-10.

Below is a summary of the cost reporting forms.

1. Worksheet S, Parts I, II & III, provides the cost report status/certification statement and settlement summary.
2. Worksheet S-1, Part I, provides RHC identification data.
3. Worksheet S-1, Part II, collects data for each RHC that files as part of a consolidated cost report.
4. Worksheet S-2, incorporates data previously reported on the Provider Cost Report Reimbursement Questionnaire, Form CMS-339.
5. Worksheet S-3, Part I, collects statistical data regarding the number and types of visits by title, as well as, the number of visits performed by interns and residents.
6. Worksheet A separately identifies general service and direct patient care costs.
7. Worksheet B, Part I & II, calculates visits and productivity standard and allowable costs of RHC services.
8. Worksheet C, Part I & II, calculates the adjusted rate per visit and the determination of the total payment.
9. Worksheet B-1 computes pneumococcal and influenza vaccine costs.
10. Worksheet C-1, provides an analysis of payments to the RHC for services rendered.

CHAPTER 46

INDEPENDENT RURAL HEALTH CLINIC
COST REPORT
FORM CMS-222-17

This page is reserved for future use.

4600. GENERAL

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

An RHC 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 for services furnished Medicare beneficiaries.

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 expiration date of this information collection instrument is April 30, 2021. The time required to complete this information collection is estimated to average 55 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 comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

4600.1 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

4601. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-222-17

Step No.	Worksheet	Instructions
1	S, Part I	Read §4603.1. Complete Part I.
2	S-1, Part I	Read §4604.1. Complete entire worksheet.
3	S-1, Part II	Read §4604.2. Complete entire worksheet.
4	S-2	Read §4605. Complete entire worksheet if applicable.
5	S-3	Read §4606. Complete entire worksheet.
6	A	Read §4607. Complete columns 1 through 3, lines 1 through 100.
7	A-6	Read §4608. Complete entire worksheet if applicable.
8	A	Read §4607. Complete columns 4 and 5, lines 1 through 100.
9	A-8-1, Parts I & II	Read §4610 through 4610.2. Complete entire worksheet if applicable.
10	A-8	Read §4609. Complete entire worksheet.
11	A	Read §4607. Complete columns 6 and 7, lines 1 through 100.
12	B, Parts I & II	Read §§4611 through 4611.2. Complete entire worksheet.
13	B-1	Read §4612. Complete if applicable.
14	C, Parts I & II	Read §§4613 through 4613.2. Complete lines 1 through 34.
15	C-1	Read §4614. Complete lines 1 through 4.
16	C, Part II	Read §§4613 through 4613.2. Complete lines 35 through 38.
17	S, Parts II & III	Read §4603.3. Complete Parts II & III.

4602. Acronyms and Abbreviations.--Throughout the Medicare cost report and instructions, a number of acronyms and abbreviations are used. For your convenience, commonly used acronyms and abbreviations are summarized below.

ACA	-	Affordable Care Act
CBSA	-	Core Based Statistical Areas
CCN	-	CMS Certification Number
CCM	-	Chronic Care Management
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare & Medicaid Services
CNM	-	Certified Nurse Midwife
COL	-	Column
CP	-	Clinical Psychologist
CSW	-	Clinical Social Worker
ECR	-	Electronic Cost Report
FR	-	Federal Register
FTE	-	Full Time Equivalents
GME	-	Graduate Medical Education
HCRIS	-	Healthcare Cost Report Information System
HRSA	-	Health Resources and Services Administration
LPN	-	Licensed Practical Nurse
MBI	-	Medicare Beneficiary Identifier
MPFS	-	Medicare Physician Fee Schedule
NP	-	Nurse Practitioner
NPR	-	Notice of Program Reimbursement
PA	-	Physician Assistant
PCRE	-	Primary Care Residency Expansion
RCE	-	Reasonable Compensation Equivalency limits
RN	-	Registered Nurse
TCM	-	Transitional Care Management
THC	-	Teaching Health Center

4603. WORKSHEET S - RURAL HEALTH CLINIC COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4603.1 Part I - Cost Report Status.--This section is to be completed by the RHC and contractor as indicated on the worksheet. If this is a consolidated cost report, the organization must choose a primary RHC whose CMS certification number (CCN) must be utilized throughout the entire cost report.

Lines 1 and 2.--The provider must check the appropriate box to indicate on line 1 or 2, whether this cost report is being filed electronically or manually. For electronic filing, indicate on line 1, columns 2 and 3 respectively, the date and time corresponding to the creation of the electronic file. This date and time remains as an identifier for the file by the contractor and is archived accordingly. Line 2 is only completed by RHCs filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter 1, §110 or RHCs demonstrating financial hardship in accordance with CMS Pub. 15-2, chapter 1, §133.

Line 3.--If this is an amended cost report, enter the number of times the cost report has been amended.

Line 4.--Enter an "F" if this is a full cost report or an "L" if this is a low Medicare utilization cost report, or an "N" if this is a no Medicare utilization cost report ("L" requires prior contractor approval, see CMS Pub. 15-2, chapter 1, §110).

Lines 5 through 12 are for contractor use only:

Line 5.--Enter the Healthcare Cost Report Information System (HCRIS) cost report status code that corresponds to the filing status of the cost report: 1=As submitted; 2=Settled without audit; 3=Settled with audit; 4=Reopened; or 5=Amended.

Line 6.--Enter the date (mm/dd/yyyy) the accepted cost report was received from the RHC.

Line 7.--Enter the 5 position contractor number.

Lines 8 and 9.--If this is an initial cost report enter "Y" for yes in the box on line 8. If this is a final cost report enter "Y" for yes in the box on line 9; if neither, enter "N". An initial report is the very first cost report for a particular RHC CCN. A final cost report is a terminating cost report for a particular RHC CCN.

Line 10.--Enter the Notice of Program Reimbursement (NPR) date (mm/dd/yyyy). The NPR date must be present if the cost report status code is 2, 3, or 4.

Line 11.--Enter the software vendor code of the cost report software used by the contractor to generate a HCRIS cost report file; use "4" for HFS or "3" for KPMG.

Line 12.--Complete this line only if the cost report status code on line 5 is "4". If this is a reopened cost report (response to line 5 cost report status, is "4"), enter the number of times the cost report has been reopened.

4603.2 Part II - Certification.--Ensure this certification page is read, prepared, and signed by the Chief Financial Officer or administrator of the RHC after the cost report has been completed in its entirety.

Effective for cost reporting periods ending on or after December 31, 2017--(1) A provider that is required to file an electronic cost report may elect to electronically submit the settlement summary and certification statement with an electronic signature of the provider's administrator or chief financial officer. The checkbox for electronic signature and submission immediately follows the certification statement as set forth in 42 CFR 413.24(f)(4)(iv)(B) and must be checked if electronic signature and submission is elected. (2) A provider that is required to file an electronic cost report but does not elect to submit the settlement summary and certification statement with an electronic signature, must submit a hard copy of the settlement summary and certification statement with an original signature of the provider's administrator or chief financial officer as set forth in 42 CFR 413.24(f)(4)(iv)(A) and (B) of this section.

4603.3 Part III - Settlement Summary.--Enter the balance due to or due from the Medicare program. Transfer the amount from Worksheet C, Part II, line 37.

4604. WORKSHEET S-1 - RURAL HEALTH CLINIC IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Rural Health Clinic Identification Data
Part II - Rural Health Clinic Consolidated Cost Report Participant Identification Data

4604.1 Part I - Rural Health Clinic Identification Data.--The information required on this worksheet is needed to properly identify the RHC, or in the case of a consolidated cost report, the primary RHC. In the case of a consolidated cost report, only the primary RHC completes the entire Worksheet S-1, Part I. All other RHCs filing under a consolidated cost report must be listed on subscripts of line 14 and must complete a separate Worksheet S-1, Part II.

Line 1, columns 1 through 4.--Enter in the appropriate column the site name, CCN, core based statistical area (CBSA) code (rural CBSA codes are assembled by placing the digits “999” in front of the two digit state code, e.g., for the state of Maryland the rural CBSA code is 99921), and certification date.

Line 1, column 5.--Indicate the type of control under which the RHC operates by entering a number from the list below:

1 = Voluntary Nonprofit, Corporation
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Governmental, Federal
8 = Governmental, State
9 = Governmental, County
10 = Governmental, City
11 = Governmental, Other

Line 2.--Enter the RHC's street address in column 1 and the post office (P.O.) box in column 2 (if applicable).

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, and county in column 4.

Line 4.--Enter the inclusive dates covered by this cost report. Enter in column 1, the cost report beginning date and enter in column 2, the cost report ending date.

Line 5.--Indicate whether this RHC is owned, leased or controlled by an entity that operates multiple RHCs. Enter a "Y" for yes or an "N" for no. If yes, complete lines 6 through 8. Otherwise, skip to line 9.

Lines 6 through 8.--Enter the name of the entity that owns, leases or controls the RHC, the street address, P.O. box (if applicable), Health Resources Services Administration (HRSA) grant award number assigned to the organization, city, state, and ZIP code.

Line 9.--Is this RHC part of a chain organization as defined in CMS Pub. 15-1, chapter 21, §2150, that claimed home office costs in a home office cost statement. Enter "Y" for yes or "N" for no. If yes, complete lines 10 through 12. Otherwise, skip to line 13.

Lines 10 through 12.--Enter the name of the chain organization, the street address, P.O. office box (if applicable), the home office CCN, city, state, and ZIP code.

Line 13.--Is this RHC filing a consolidated cost report under CMS Pub. 100-02, chapter 13, §80.2. Enter "Y" for yes or "N" for no, in column 1. If yes, enter in column 2 the date the RHC requested approval to file a consolidated cost report, in column 3 the date the contractor approved the RHC's request to file a consolidated cost report, and in column 4 the number of RHCs included in this consolidated cost report other than the primary RHC.

Line 14.--If the response to line 13, column 1 is yes, list on line 14, beginning with the subscript line 14.01, each RHC that is part of this consolidated cost report, excluding the RHC listed on line 1. Enter in column 1 the site name, column 2 the CCN, column 3 the CBSA, column 4 the date the RHC requested approval to file as part of a consolidated cost report, and column 5 the date the contractor approved the RHCs request to file as part of a consolidated cost report. Each RHC listed on line 14, beginning with the subscript line 14.01, must complete a separate Worksheet S-1, Part II.

Line 15.--Indicate if your RHC carries commercial malpractice coverage. Enter "Y" for yes or "No" for no. Malpractice insurance premiums are money paid by the RHC to a commercial insurer to protect the RHC against potential negligence claims made by their patients/clients.

Line 16.--If line 15 is yes, indicate if your malpractice insurance is a claims-made or occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. Enter 1 if the malpractice insurance is a claims-made policy. Enter 2 if the malpractice insurance is an occurrence policy.

Line 17.--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.

Malpractice paid losses is money paid by the RHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the RHC where the RHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often RHCs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage the RHC needs but could not obtain economically through the mainstream insurance market.

Line 18.--Indicate if malpractice premiums paid, paid losses, or self-insurance are reported in a cost center other than the Malpractice Premiums cost center, Worksheet A, line 28. Enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing cost centers and amounts.

Line 19.--Is this RHC and/or any consolidated RHCs involved in training residents in an approved graduate medical education (GME) program in accordance with 42 CFR 405.2468(f)? Enter "Y" for yes or "N" for no.

Line 20.--Have you received an approval for an exception to the productivity standard? Enter "Y" for yes and "N" for no.

Line 21.--Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.

Line 22.--If line 21 is yes, enter the type of operation (i.e., laboratory or physicians services).

Line 23.--Enter on lines 23.01 through 23.07 the hours of operation (from/to) based on a 24 hour clock next to the appropriate day that the facility is available to provide RHC services. For example 8:00 am is 0800 and 5:30 pm is 1730.

Line 24.--If line 23 is yes, enter on lines 24.01 through 24.07 the hours of operation (from/to) next to the appropriate day that the facility is available to provide other than RHC services.

Line 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. If the RHC participated in more than one demonstration, subscript this line as applicable.

Line 26.--Are there any related organization costs claimed as defined in CMS Pub. 15-1 chapter 10? Enter "Y" for yes or "N" for no. If yes, complete worksheet A-8-1.

4604.2 Part II - Rural Health Clinic Consolidated Cost Report Identification Data.-Each RHC that is included on Worksheet S-1, Part I, line 14, and applicable subscripts, who is filing as part of a consolidated cost report must complete a separate Worksheet S-1, Part II in the identical sequence that the consolidated RHCs are reported on Worksheet S-1, Part I, line 14 and its subscripts. Do not complete this worksheet for the primary RHC reported on Worksheet S-1, Part I, line 1.

Line 1.--Enter the RHC site name in column 1 and the RHC certification date in column 2. Indicate the type of control under which the RHC operates by entering a number from the list below in column 3.

1 = Voluntary Nonprofit, Corporation	7 = Governmental, Federal
2 = Voluntary Nonprofit, Other	8 = Governmental, State
3 = Proprietary, Individual	9 = Governmental, County
4 = Proprietary, Corporation	10 = Governmental, City
5 = Proprietary, Partnership	11 = Governmental, Other
6 = Proprietary, Other	

Enter the date the RHC terminated its participation in the Medicare program (if applicable) in column 4. In column 5, enter a "V" for a voluntary termination or an "I" for an involuntary termination.

If the RHC changed ownership immediately prior to the beginning of the cost reporting period enter the date of the change of ownership in column 6. Also submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Enter the RHC's street address in column 1 and the P.O. box in column 2 (if applicable).

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, and county in column 4.

Line 4.--Indicate if your RHC carries commercial malpractice coverage. Enter "Y" for yes or "N" for no. Malpractice insurance premiums are money paid by the RHC to a commercial insurer to protect the RHC against potential negligence claims made by their patients/clients.

Line 5.--If line 4 is yes, indicate if your malpractice insurance is a claims-made or occurrence policy. A claims-made insurance policy covers claims first made (reported or filed) during the year the policy is in force for any incidents that occur that year or during any previous period during which the insured was covered under a "claims-made" contract. The occurrence policy covers an incident occurring while the policy is in force regardless of when the claim arising out of that incident is filed. Enter 1 if the malpractice insurance is a claims-made policy. Enter 2 if the malpractice insurance is an occurrence policy.

Line 6.--Enter the total amount of malpractice premiums paid in column 1, enter the total amount of paid losses in column 2, and enter the total amount of self-insurance paid in column 3.
Malpractice paid losses is money paid by the RHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the RHC where the RHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often RHCs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage the RHC needs but could not obtain economically through the mainstream insurance market.

Line 7.--Does the facility operate as other than a RHC? Enter "Y" for yes or "N" for no.

Line 8.--If line 7 is yes, enter the type of operation (i.e., laboratory or physicians services).

Line 9.--Enter on lines 9.01 through 9.07 the hours of operation (from/to) based on a 24 hour clock next to the appropriate day that the facility is available to provide RHC services. For example 8:00 am is 0800 and 5:30 pm is 1730.

Line 10.--If 7 is yes, enter on lines 10.01 through 10.07 the hours of operation (from/to) next to the appropriate day that the facility is available to provide other than RHC services.

4605. WORKSHEET S-2 - RURAL HEALTH CLINIC REIMBURSEMENT QUESTIONNAIRE

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the RHC to submit documentation/information, mail or otherwise transmit the requested documentation to the contractor with submission of the electronic cost report (ECR). The contractor has the right under §§1815(a) and 1883(e) of the Act to request any missing documentation. When filing a consolidated cost report, this worksheet applies only to the primary RHC.

To the degree that the information in the questionnaire constitutes commercial or financial information which is confidential and/or is of a highly sensitive personal nature, the information will be protected from release under the Freedom of Information Act. If there is any question about releasing information, the contractor should consult with the CMS Regional Office.

NOTE: The responses on all lines are "yes" or "no" unless otherwise indicated. When the instructions require documentation, indicate on the documentation the Worksheet S-2 line number the documentation supports. Lines 1 through 19 are required to be completed by all RHCs reported on Worksheet S-1, Part I, line 1.

Line 1.--Indicate whether the RHC has changed ownership immediately prior to the beginning of the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date the change of ownership occurred in column 2. Also, submit the name and address of the new owner and a copy of the sales agreement with the cost report.

Line 2.--Indicate whether the RHC has terminated participation in the Medicare program. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the date of termination in column 2, and "V" for voluntary or "I" for involuntary in column 3.

Line 3.--Indicate whether the RHC is 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 RHC or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a list of the individuals, the organizations involved, and a description of the transactions with the cost report.

NOTE: A related party transaction occurs when services, facilities, or supplies are furnished to the provider by organizations related to the provider through common ownership or control. (See Pub. 15-1, chapter 10 and 42 CFR 413.17.)

Line 4.--Indicate in column 1 whether the financial statements were prepared by a certified public accountant; enter "Y" for yes or "N" for no. If column 1 is yes, indicate the type of financial statements in column 2 by entering "A" for audited, "C" for compiled, or "R" for reviewed. Submit a complete copy of the financial statements (i.e., the independent public accountant's opinion, the statements themselves, and the footnotes) with the cost report. If the financial statements are not available for submission with the cost report enter the date they will be available in column 3. Indicate whether the total expenses and total revenues reported on the cost report differ from those on the filed financial statements? Enter "Y" for yes or "N" for no in column 4. If "Y", submit a reconciliation with the cost report.

If column 1 is "N", submit a copy of the internally prepared financial statements, and written statements of significant accounting policy and procedure changes affecting Medicare reimbursement which occurred during the cost reporting period. You may submit the changed accounting or administrative procedures manual in lieu of written statements.

Line 5.--Indicate whether Intern-Resident costs were claimed on the current cost report. Enter "Y" for yes or "N" for no in column 1.

Line 6.--Indicate whether Intern-Resident program(s) have been initiated or renewed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit copies of the certification(s)/program approval(s) with the cost report. (See 42 CFR 413.79(l) for the definition of a new program.)

Line 7.--Indicate whether graduate medical education costs were directly assigned to cost centers other than the "Allowable GME Costs" on Worksheet A, line 29. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a listing of the cost centers and amounts with the cost report.

Line 8.--Indicate whether you are seeking reimbursement for bad debts resulting from Medicare deductible and/or coinsurance amounts which are uncollectible from Medicare beneficiaries. (See 42 CFR 413.89(e) and CMS Pub. 15-1, chapter 3, §§306 - 324 for the criteria for an allowable bad debt.) Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a completed Exhibit 1 or internal schedule duplicating, at a minimum, the documentation requested on Exhibit 1 to support the bad debts claimed.

Exhibit 1 requires the following documentation:

Columns 1, 2, 3, 4 - Patient Names, Medicare Beneficiary Identifier (MBI) Number, and Dates of Service (From - To).--The documentation required for these columns is derived from the beneficiary's bill. Furnish the patient's name, MBI number and dates of service that correlate to the claimed bad debt. (See CMS Pub. 15-1, chapter 3, §314 and 42 CFR 413.89.)

Columns 5 & 6--Indigency/Medicaid Beneficiary.--If the patient included in column 1 has been deemed indigent, place a check in column 5. If the patient in column 1 has a valid Medicaid number, include this number in column 6. See the criteria in CMS Pub. 15-1, chapter 3, §§312 and 322 and 42 CFR 413.89 for guidance on the billing requirements for indigent and Medicaid beneficiaries.

Columns 7 & 8--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased.--This information should be obtained from the RHC's files and should correlate with the beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3 and 4 of this exhibit. The date in column 8 represents the date that the unpaid account is deemed worthless, whereby all collection efforts, both internal and by an outside entity, ceased and there is no likelihood of recovery of the unpaid account. (See 42 CFR 413.89(e) and (f), and CMS Pub. 15-1, chapter 3, §§308, 310, and 314.)

Column 9--Medicare Remittance Advice Dates.--Enter in this column the remittance advice dates that correlate with the beneficiary name, MBI number, and dates of service shown in columns 1, 2, 3, and 4 of this exhibit.

Column 10--Coinsurance/Total Medicare Bad Debts.--Record on each line of this column the beneficiary's unpaid coinsurance amount that relates to covered services. Calculate the total bad debts by summing up the amounts on all lines of column 10. This "total" must agree with the bad debts claimed on the cost report. Attach additional supporting schedules, if necessary, for bad debt recoveries.

Line 9.--If line 8 is yes, indicate whether your bad debt collection policy changed during the cost reporting period. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, submit a copy of the revised bad debt collection policy with the cost report.

Line 10.--If line 8 is yes, indicate whether patient coinsurance amounts were waived. Enter "Y" for yes or "N" for no in column 1. If you answer "Y" in column 1, ensure that they are not included on the bad debt listings (i.e., Exhibit 1 or your internal schedules) submitted with the cost report.

Line 11.--Indicate whether the cost report was prepared using the Provider Statistical & Reimbursement (PS&R) Report only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R in column 2. Also, submit a crosswalk between revenue codes and visits found on the PS&R to the cost center groupings on the cost report. This crosswalk will reflect a cost center to revenue code match only.

Line 12.--Indicate whether the cost report was prepared using the PS&R for totals and the RHC's records for allocation. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" enter the paid through date of the PS&R used to prepare this cost report in column 2. Also, submit a detailed crosswalk between revenue codes and visits on the PS&R to the cost center groupings on the cost report. This crosswalk must show visits by cost center and include which revenue codes were allocated to each cost center. The total visits on the cost report must match the total visits on the PS&R (as appropriately adjusted for unpaid claims, etc.) to use this method. Supporting work papers must accompany this crosswalk to provide sufficient documentation as to the accuracy of the RHCs records.

Line 13.--If you entered "Y" on either line 11 or 12, indicate whether adjustments were made to the PS&R data for additional claims that have been billed but not included on the PS&R used to file this cost report. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a schedule which supports any claims not included on the PS&R. This schedule should include totals consistent with the breakdowns on the PS&R, and should reflect claims that are unprocessed or unpaid as of the cut-off date of the PS&R used to file the cost report.

Line 14.--If you entered "Y" on either line 11 or 12, column 1, indicate whether adjustments were made to the PS&R data for corrections of other PS&R information. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit a detailed explanation and documentation which provides an audit trail from the PS&R to the cost report.

Line 15.--If you entered "Y" on either line 11 or 12, column 1, indicate whether other adjustments were made to the PS&R data. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", include a description of the other adjustments and documentation which provides an audit trail from the PS&R to the cost report.

Line 16.--Indicate whether the cost report was prepared using RHC records only. Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", submit detailed documentation of the system used to support the data reported on the cost report. If detailed documentation was previously supplied, submit only necessary updated documentation with the cost report.

The minimum requirements are:

- Internal records supporting program utilization statistics, charges, prevailing rates and payment information broken into each Medicare bill type in a manner consistent with the PS&R report.

- A reconciliation of remittance totals to the provider's internal records.

- The name of the system used and system maintainer (vendor or RHC). If the RHC maintained the system, include date of last software update.

NOTE: Additional information may be supplied such as narrative documentation, internal flow charts, or outside vendor informational material to further describe and validate the reliability of your system.

Line 17.--Enter the first name, last name, and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.

Line 18.--Enter the employer/company name of the cost report preparer.

Line 19.--Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.

EXHIBIT 1
LISTING OF MEDICARE BAD DEBTS AND APPROPRIATE SUPPORTING DATA

RHC Name _____ Prepared By _____
RHC CCN _____ Date Prepared _____
FYE _____

Patient Name	MBI. No.	Dates of Service		Indigency& Medicaid Beneficiary (Check if applicable)		Date First Bill Sent to Beneficiary	Date Collection Efforts Ceased	Medicare Remittance Advice Dates	Co-Insurance/ Total Medicare Bad Debts*
		From	To	Yes	Medicaid Number				
1	2	3	4	5	6	7	8	9	10

*These amounts must not be claimed unless the RHC bills for these services with the intention of receiving payment.
See instructions for columns 5 and 6 - Indigency/Medicaid Beneficiary, for possible exception.
These amounts must not be claimed if they were included on a previous Medicare bad debt listing or cost report.

Rev. 1

4606. WORKSHEET S-3 - RURAL HEALTH CLINIC STATISTICAL DATA

This worksheet collects statistical data regarding the number and types of visits by title, as well as, the number of visits performed by interns and residents. Only those visits that qualify as a face to face encounter associated with a beneficiary receiving services under the Medicare fee for service program are included in column 2. Visits attributable to beneficiaries enrolled in a Medicare Advantage plan must be included in column 4. For the purposes of the Medicare program, a beneficiary who receives care at an RHC can be seen for three types of visits:

- Medical Visit - A face to face encounter between an RHC patient and one of the following: a physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or licensed practical nurse. The provision of Transitional Care Management (TCM) services is reported as a medical visit if it is the only medical service provided on that day and it meets the TCM billing requirements. If it is furnished on the same day as another medical visit, only one medical visit is reported on the cost report.
- Medical Visit for Subsequent Illness or Injury.
- Mental Health Visit - A face to face encounter between an RHC patient and one the of the following: a clinical psychologist, clinical social worker, or a physician, physician assistant, nurse practitioner, certified nurse midwife, registered nurse, or a licensed practical nurse for mental health services.

All visits performed by interns and residents who are funded by a Teaching Health Center (THC) or Primary Care Residency Expansion (PCRE) grant from HRSA must be included in column 4 (other), lines 1 through 4, as applicable, on this worksheet.

Column 0.--Use this column to identify the primary RHC listed on Worksheet S-1, Part I, line 1, and if you are filing a consolidated cost report, each RHC listed on Worksheet S-1, Part I, line 14, beginning with the subscripted line 14.01, in the exact same order.

Columns 1 through 3.--Enter the number of medical visits, mental health visits, and visits performed by interns and residents, if applicable, for each program (title V, title XVIII, and title XIX). Intern and resident visits are a subset of the medical or mental health visits. Include dually eligible (Medicare/Medicaid) beneficiaries in column 2.

Column 4.--Enter the number of medical visits, mental health visits, and visits performed by interns and residents, for all other payors by adding visits in columns 1 through 3 and subtracting from total visits reported in column 5.

Column 5.--Enter the total medical visits, mental health visits, and visits performed by interns and residents, for the entire facility. The total in this column will be used to compute all other payors in column 4.

Line 1.--Enter the number of medical visits applicable to columns 1 through 3, and 5. Each visit to the RHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the RHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 1 must contain the medical visits exclusively for the primary CCN and you must subscript line 1 to report the number of medical visits for each additional RHC included in this consolidated cost report. Each subscript of line 1, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14, beginning with subscripted line 14.01, in the exact same order. Enter the number of medical visits applicable to columns 1 through 3, and 5, for each RHC listed on line 1 and its subscripts.

Line 2.--Enter the total number of medical visits (sum of line 1 and its subscripts) for each applicable column.

Line 3.--Enter the number of mental health visits applicable to columns 1 through 3, and 5. Each visit to the RHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the RHC in the same day for a subsequent illness or injury. If you are filing under a consolidated cost report, line 3 must contain the mental health visits exclusively for the primary CCN and you must subscript line 3 to report the number of mental health visits for each additional RHC included in this consolidated cost report. Each subscript of line 3, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14, beginning with subscripted line 14.01, in the exact same order. Enter the number of mental health visits applicable to columns 1 through 3, and 5, for each RHC listed on line 3 and its subscripts.

Line 4.--Enter the total number of mental health visits (sum of line 3 and its subscripts) for each applicable column.

Line 5.--Enter the total number of visits performed by interns and residents applicable to columns 1 through 3, and 5. If you are filing under a consolidated cost report, line 5 must contain the visits performed by interns and residents exclusively for the primary CCN and you must subscript line 5 to report the number of visits performed by interns and residents for each additional RHC included in this consolidated cost report. Visits reported on line 5 and its subscripts, are a subset of the medical and mental health visits reported on lines 1 and 3 and their subscripts. Each subscript of line 5, column 0, must contain a corresponding CCN from Worksheet S-1, Part I, line 14, beginning with subscripted line 14.01, in the exact same order. Enter the number of visits performed by interns and residents applicable to columns 1 through 3, and 5 for each RHC listed on line 5 and its subscripts.

Line 6.--Enter the total number of visits performed by interns and residents (sum of line 5 and its subscripts) for each applicable column.

Line 7.--Enter the total number of medical and mental health visits (sum of lines 2 and 4).

NOTE: When reporting data for RHCs reporting under the consolidated cost reporting provisions, subscript lines 1, 3, and 5 in the identical sequence that the consolidated RHCs are reported on Worksheet S-1, Part I, line 14, beginning with subscripted line 14.01.

4607. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Use Worksheet A to record the trial balance of expense accounts from your accounting books and records. The worksheet also provides for the necessary reclassifications and adjustments to certain accounts. All cost centers listed do not apply to all RHCs using this worksheet. For example, an RHC that does not have an intern and resident program will not complete lines 29 and/or 78. In addition to those lines listed, the worksheet also provides blank lines for other RHC cost centers. Complete only those lines that are applicable.

If the cost elements of a cost center are maintained separately on your books, a reconciliation of costs per the accounting books and records to those on this worksheet must be maintained and are subject to review by your contractor.

Standard (i.e., preprinted) CMS line numbers and cost center descriptions cannot be changed. If additional or different cost center descriptions are needed, add additional lines to the cost report. Where an added cost center description bears a logical relationship to a standard line description, the added label must be inserted immediately after the related standard line. Added cost centers must be appropriately coded. Identify the added line as a numeric subscript of the immediately preceding line. That is, if two lines are added between lines 25 and 26, identify them as lines 25.01 and 25.02.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care providers on the Medicare cost reports. The Form CMS-222-17 provides for preprinted cost center descriptions that may apply to RHC services on Worksheet A. In addition, a space is provided for a cost center code. The preprinted cost center labels are automatically coded by CMS approved cost reporting software, hereafter referred to as the standard cost centers. One additional cost center description with general meaning has been identified. This additional description will hereafter be referred to as a nonstandard label with an "Other..." designation to provide for situations where no match in meaning to the standard cost centers can be found. Refer to Worksheet A, line 10. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

The use of this coding methodology allows providers to continue to use labels for cost centers that have meaning within the individual institution. The four digit cost center codes that are associated with each RHC's label in their electronic file provide standardized meaning for data analysis. RHCs are required to compare any added or changed label to the descriptions offered on the standard or nonstandard cost center tables. A description of cost center coding and the table of cost center codes are in §4695, Table 5 of the electronic reporting specifications.

Also, submit the working trial balance of the facility with the cost report. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and is used as a basic summary for financial statements.

Column Descriptions

Columns 1 through 3.--The expenses listed in these columns must be in accordance with your accounting books and records.

Enter on the appropriate lines in columns 1 through 3 the total expenses incurred during the reporting period. Detail the expenses as salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3. Record any needed reclassification and adjustments in columns 4 and 6, as appropriate.

Column 1.--Salaries are the gross salaries paid to employees before taxes and other items are withheld. Salaries include paid vacation, holiday, sick, other-paid-time off, severance and bonus pay. (See CMS Pub. 15-1, chapter 21.) Enter salaries from the RHC's accounting books and records. Do not include costs attributable to contracted labor in this column. Contracted labor is only reported in column 2.

Column 2.--Enter all costs other than salaries from the RHC's accounting books and records.

Column 3.--For each cost center, add the amounts in columns 1 and 2 and enter the total in column 3.

Column 4.--For each cost center, enter the net amount of reclassifications from Worksheet A-6. The net total of the entries in column 4 must equal zero on line 100. Show reductions to expenses as negative numbers.

Column 5.--Adjust the amounts entered in column 3 by the amounts in column 4 (increase or decrease) and extend the net balances to column 5. The total of column 5, line 100, must equal the total of column 3, line 100.

Column 6.--Enter on the appropriate lines the amounts of any adjustments to expenses indicated on Worksheet A-8, column 2. The total on Worksheet A, column 6, line 100, must equal the amount on Worksheet A-8, column 2, line 50.

Column 7.--Adjust the amounts in column 5 by the amounts in column 6 (increases or decreases) and extend the net balances to column 7.

Transfer the amounts in column 7 to the appropriate lines on Worksheet B and Worksheet B-1.

Line Descriptions

Line 1 - Physician.--This cost center includes the costs incurred by the RHC for physicians providing direct patient care services and general supervisory services, participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the governing board. The costs incurred for teaching physicians and interns and residents must be reported on line 29. Physician services provided under an agreement are reported on line 15.

Line 2 - Physician Assistant.--This cost center includes the costs incurred by the RHC for physician assistants (PA), including the costs for PAs providing physician services.

Line 3 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners (NP), including NPs providing physician services.

Line 4 -- Certified Nurse Midwife.--This cost center includes the costs of services provided by a Certified Nurse Midwife (CNM).

Line 5 - Registered Nurse.--This cost center only includes the costs of nursing care provided by registered nurses (RNs) who perform nurse services in accordance with CMS Pub. 100-02, chapter 13, §190.

Line 6 - Licensed Practical Nurse.--This cost center only includes the costs of nursing care provided by licensed practical nurses (LPNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §190.

This page is reserved for future use.

Line 7 - Clinical Psychologist.--This cost center includes the costs of a clinical psychologist (CP) who holds a doctorate in psychology and is licensed or certified by the State in which he or she practices, for diagnostic, assessment, preventative and therapeutic services directed at individuals.

Line 8 - Clinical Social Worker.--This cost center includes the costs of a clinical social worker (CSW) who possesses a master's degree or doctorate in social work and meets specified criteria established by regulation. The CSW must directly examine the patient, or directly review the patient's medical information, to provide diagnosis, treatment and consultation.

Line 9 - Laboratory Technician.--This cost center includes the costs of a person who, under the supervision of a medical technologist or physician, performs microscopic and bacteriologic tests of human blood, tissue, and fluid for diagnostic and research purposes.

Line 10.--Enter costs for all other health care staff not entered on lines 1 through 9.

Line 14.--Enter the sum of the amounts on lines 1 through 10.

Lines 11 through 13.--Reserved for future use.

Line 15 - Physician Services Under Agreement.--This cost center includes the costs incurred by the RHC for physicians services that are provided on a short term or irregular basis under agreements.

Line 16 - Physician Supervision Under Agreement.--This cost center includes the costs incurred by the RHC for physician supervision services under agreement.

Line 17.--Enter the sum of the amounts on lines 15 and 16.

Lines 18 through 24.--Reserved for future use.

Line 25 - Medical Supplies.--This cost center includes the routine cost of supplies used in the normal course of caring for patients, such as gloves, masks, swabs, or glycerin sticks, and the non-routine costs of medical supplies that can be traced to individual patients.

Line 26 - Transportation (Health Care Staff).--This cost center includes the cost of owning or renting vehicles, public transportation expenses, parking, tolls, or payments to employees for driving their private vehicles to see patients or for other RHC business.

Line 27 - Depreciation-Medical Equipment.--Enter the medical equipment depreciation expense.

Line 28 - Malpractice Premiums.--Enter the malpractice premiums expense for the cost reporting period.

Line 29 - Allowable GME Costs.--Enter the total allowable interns and residents costs. This cost center includes the costs associated with allowable direct GME costs set forth in 42 CFR 405.2468(f). These include residents' salaries and fringe benefits (including travel and lodging expenses where applicable); the allowable portion of the teaching physicians' salaries and fringe benefits that are related to the time spent teaching and supervising residents (i.e., lecture time, time spent filling out resident evaluations, mentoring, and program development) subject to the

reasonable compensation equivalency limits (RCEs) (42 CFR 415.70); and overhead costs that are directly assigned to the intern and resident program. If the overhead costs for the direct GME are not identified and recorded on this line in columns 1 or 2, a reclassification to this cost center is required. The reclassification must be made on a factual and auditable basis on Worksheet A-6 (see §4608).

Additionally, an RHC must include all allowable direct costs associated with an intern and/or resident program funded by a THC and/or PCRE grant from HRSA on line 29, only if the program meets the requirements set forth in 42 CFR 405.2468(f). If the direct costs associated with an intern and/or resident who is funded by a THC and/or PCRE grant are included in line 29, the RHC must reclassify the direct costs associated with the THC and/or PCRE programs funded by HRSA to line 78, nonallowable GME costs.

A "moonlighting" resident or fellow is a postgraduate medical trainee who is practicing independently, outside the scope of his or her residency training program and would be treated as a physician within the scope of the privileges granted by the RHC. Therefore, costs associated with a "moonlighting" intern or resident are reported in the physician services cost center, not the allowable GME cost center.

Line 30 - Pneumococcal Vaccines & Med Supplies.--This cost center includes the cost of the pneumococcal vaccines and the medical supplies attributable to pneumococcal vaccinations.

Line 31 - Influenza Vaccines & Med Supplies.--This cost center includes the cost of the influenza vaccines and the medical supplies attributable to influenza vaccinations.

Line 32.--Enter the expenses of other health care costs not entered on lines 25 through 31.

Line 38.--Enter the sum of the amounts on lines 25 through 32.

Line 39.--Enter the sum of the amounts on lines 14, 17, and 38. Transfer the total amount in column 7 to Worksheet B, Part II, line 12 reduced by the amount on line 29, column 7.

Lines 33 through 37.--Reserved for future use.

Lines 40 through 48.--Enter the overhead expenses related to the facility.

Line 59.--Enter the sum of the amounts on lines 40 through 48.

Lines 49 through 58.--Reserved for future use.

Lines 60 through 68.--Enter the expenses related to the administration and management of the RHC.

Lines 69 through 72.--Reserved for future use.

Line 73.--Enter the sum of the amount on lines 60 through 68.

Line 74.--Enter the sum of lines 59 and 73. Transfer the total amount in column 7 to Worksheet B, Part II, line 16.

Line 75 - Pharmacy.--This cost center includes only the costs of routine drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel, and pharmacy services, provided incident to an RHC visit.

Line 76 - Dental.--Enter the cost incurred for dental services rendered (excluding overhead).

Line 77 - Optometry.--Enter the cost incurred for optometry services rendered (excluding overhead).

Line 78 - Nonallowable GME Pass Through Costs.--This cost center includes the costs associated with an intern and resident program not approved by Medicare.

Line 79 - Telehealth.--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §200.

Line 80 - Chronic Care Management.--This cost center includes the cost related to the structured recording of patient health information, an electronic health care plan addressing all health issues, access to chronic care management (CCM) services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. CCM services are reimbursed as an add-on payment based on the Medicare Physician Fee Schedule (MPFS). See 80 FR 71080 (November 16, 2015).

Line 81.--Enter the cost applicable to services other than RHC services (excluding overhead) not entered on lines 75 through 80.

Lines 82 through 85.--Reserved for future use.

Line 86.--Enter the sum of the amounts on lines 75 through 81.

Line 87 through 89.--Enter other cost of services that are not reimbursable under Medicare.

Line 90.--Enter the sum of the amounts on lines 87 through 89.

Lines 91 through 99.--Reserved for future use.

Line 100.--This is the total cost of the facility. It is the sum of the amounts on lines 39, 74, 86, and 90.

4608. WORKSHEET A-6 - RECLASSIFICATIONS

This worksheet provides for the reclassification of certain amounts to effect the proper cost allocation. The cost centers affected must be specifically identifiable in your accounting records. Use reclassifications in instances in which the expenses applicable to more than one of the cost centers listed on Worksheet A are maintained in your accounting books and records in one cost center. For example, if a physician performs administrative duties, the appropriate portion of his/her compensation, payroll taxes and fringe benefits must be reclassified from "Facility Health Care Staff Cost" to "Facility Overhead", line 60 for the office salaries and line 67 for the benefits and taxes.

Column 1.--Identify each reclassification adjustment by assigning an alpha character (e.g., A, B, C) in column 1. Do not use numeric designations.

Columns 2, 3, and 4.--For each increase reclassification, enter the corresponding cost center description in column 2, the Worksheet A cost center line number reference in column 3, and reclassification amount in column 4.

Columns 5, 6, and 7.--For each decrease reclassification, enter the corresponding cost center description in column 5, the Worksheet A cost center line number reference in column 6, and reclassification amount in column 7.

4609. WORKSHEET A-8 - ADJUSTMENTS TO EXPENSES

This worksheet provides for adjusting the expenses listed on Worksheet A, column 5. Make these adjustments, which are required under the Medicare principles of reimbursement, on the basis of cost, or amount received. Enter the total amount received (revenue) only if the cost (including the direct cost and all applicable overhead) cannot be determined. However, if total direct and indirect cost can be determined, enter the cost. Once an adjustment to an expense is made on the basis of cost, you may not, in future cost reporting periods determine the required adjustment to the expense on the basis of revenue. Enter the following symbols in column 1 to indicate the basis for adjustments: "A" for costs and "B" for amount received. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred for reasons other than patient care and, thus, require adjustments.

Types of items to be entered on this worksheet are (1) those needed to adjust expenses incurred, (2) those items which constitute recovery of expenses through sales, charges, fees, etc., and (3) those items needed to adjust expenses in accordance with the Medicare principles of reimbursement. (See CMS Pub. 15-1, chapter 23, §2328.)

If an adjustment to an expense affects more than one cost center, record the adjustment to each cost center on a separate line on this worksheet.

Columns 2, 3, and 4.--For each adjustment, enter the amount in column 2, enter the Worksheet A cost center line number reference in column 4, and enter the corresponding cost center description in column 3.

Line Descriptions

Lines 1 through 3.--Investment income on restricted and unrestricted funds which are commingled with other funds must be applied together against, but should not exceed, the total interest expense included in allowable costs. (See CMS Pub. 15-1, chapter 2.)

Apply the investment income on restricted and unrestricted funds which are commingled with other funds against the administrative and general, the capital-related - buildings and fixtures, the capital-related - moveable equipment and any other appropriate cost centers on the basis of the ratio that interest expense charged to each cost center bears to the total interest expense charged to all of your cost centers.

Line 7.--Enter the amount from Worksheet A-8-1, column 6, line 5.

Line 10.--Enter the amount which represents the allowable cost of the services furnished by Public Health Service personnel. Obtain this amount from your contractor.

Lines 11 and 12.--If depreciation expense computed in accordance with Medicare principles of reimbursement differs from depreciation expenses per your books, enter the difference on lines 11 and/or 12.

Line 13.--Enter RCE adjustment for teaching physicians. RCE limits apply to the portion of the teaching physician's salary associated with teaching residents (i.e., lecture time, time spent filling out resident evaluations, mentoring, and program development, etcetera as these activities are "direct GME" activities). See CMS Pub. 15-1, chapter 21.

Line 14 through 49.--Enter any additional adjustments required under the Medicare principles of reimbursement. Label the lines appropriately to indicate the nature of the required adjustments.

Line 50--Enter the sum of lines 1 through 49. Transfer the amounts in column 2 to the appropriate lines on Worksheet A, column 6.

4610. WORKSHEET A-8-1 - STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

In accordance with 42 CFR 413.17, costs applicable to services, facilities, and supplies furnished to the RHC by organizations related to the RHC by common ownership or control are includable in your allowable cost at the cost to the related organization, except for the exceptions outlined in 42 CFR 413.17(d). This worksheet provides for the computation of any needed adjustments to costs applicable to services, facilities, and supplies furnished to the RHC by organizations related to the RHC or costs associated with a home office. However, such cost must not exceed the amount a prudent and cost conscious buyer pays for comparable services, facilities, or supplies that are purchased elsewhere.

4610.1 Part I - Costs Incurred and Adjustments Required as a Result of Transactions with Related Organizations or Claimed Home Office Costs.--This part of the worksheet provides for the computation of adjustments needed to properly report costs of services, facilities, and supplies furnished to the RHC by related organizations or costs associated with the home office.

Columns 1 and 2.--Enter in column 1 the Worksheet A cost center line number to be adjusted. Enter the corresponding cost center description in column 2.

Column 3.--Enter the description of the related organization or home office expense item.

Column 4.--Enter the allowable costs from the books and/or records of the related organization or home office. Allowable costs are the actual costs incurred by the related organization or home office for services, facilities, and/or supplies and exclude any markup, profit or amounts that otherwise exceed the acquisition cost of such items.

Column 5.--Enter the amount included on Worksheet A for services, facilities, and/or supplies acquired from related organizations and/or a home office.

Column 6.--Enter the result of column 4 minus column 5.

4610.2 Part II - Interrelationship to Related Organizations and/or Home Office.--This part of the worksheet identifies the interrelationship between the RHC and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the RHC as defined in CMS Pub. 15-1, chapter 10. Complete columns 1 through 6 as applicable for each interrelationship.

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

Column 1.--Enter the symbol that represents the interrelationship between the RHC and the related organization or home office. Select from the following choices:

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

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

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

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

Column 5.--If the RHC, or an individual reported in column 2, has a financial interest in the organization reported in column 4, enter the percent of ownership.

Column 6.--Enter the type of business of the related organization (e.g., medical drugs and/or supplies, janitorial services).

4611. WORKSHEET B - VISITS AND OVERHEAD COST FOR RHC SERVICES

Worksheet B is used by the RHC to summarize (1) the visits furnished by your health care staff and by physicians under agreements with you, and (2) the overhead costs incurred by you which apply to RHC services.

4611.1 Part I - Visits and Productivity.--Use Part I to summarize the number of facility visits furnished by the health care staff and to calculate the number of visits to be used in the rate determination. Productivity standards established by CMS are applied as a guideline that reflects the total combined services of the staff. Apply a level of 4200 visits for each physician and a level of 2100 visits for each nonphysician practitioner. (See CMS Pub. 100-02, chapter 13, §80.4)

Lines 1 through 11 (and applicable subscripts) of Part I list the types of practitioners (positions) for whom facility visits must be counted and reported.

Line 1--Enter the number of full time equivalents (FTEs) and total visits furnished to facility patients by staff physicians working at the facility on a regular ongoing basis. Also include on this line, physician data (FTEs and visits) for services furnished to facility patients by staff physicians working under contractual agreement with you on a regular ongoing basis in the RHC facility. These physicians are subject to productivity standards.

Column 1.--Record the number of all FTE personnel in each of the applicable staff positions in the facility practice.

Column 2.--Record the total visits actually furnished to all patients by all personnel in each of the applicable staff positions in the reporting period. Count visits in accordance with instructions in 42 CFR 405.2463(a) defining a visit.

Column 3.--Productivity standards established by CMS are guidelines that reflect the total combined services of the staff. Apply a level of 4200 visits for each physician and 2100 visits for each nonphysician practitioner. However, if you were granted an exception to the productivity standards (answered yes to question 22 of Worksheet S-1, Part I), enter on lines 1 through 3 the number of productivity visits approved by the contractor.

Contractors have the authority to waive productivity guidelines in cases where you have demonstrated reasonable justification for not meeting the standard. In such cases, the contractor may set any number of visits as reasonable (not just actual visits) if an exception is granted. For example, if the guideline is 4200 visits and you furnished only 1000 visits, the contractor may permit 2500 visits to be used in the calculation.

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 5.--Enter the total of lines 1 through 4.

Line 10.--Enter the total of lines 5 through 9.

Line 11.--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 facility. Physician's 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 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.

4611.2 Part II - Determination of Total Allowable Cost Applicable to RHC Services.--Use Part II to determine the amount of overhead cost applicable to RHC services.

Line 12.--Enter the cost of RHC services (excluding overhead and allowable GME costs) from Worksheet A, column 7, line 39, less the amount on Worksheet A, column 7, line 29.

Line 13.--Enter the cost of services (other than RHC services) excluding overhead from Worksheet A, column 7, sum of lines 86 and 90.

Line 14.--Enter the cost of all services (excluding overhead), determined as the sum of lines 12 and 13.

Line 15.--Enter the percentage of RHC services. This percentage is determined by dividing the amount on line 12 (the cost of RHC services) by the amount on line 14 (the cost of all services, excluding overhead).

Line 16.--Enter the total overhead costs incurred from Worksheet A, column 7, line 74. It is the sum of facility costs and administrative overhead costs.

Line 17.--Enter the overhead amount applicable to RHC services. Multiply the ratio on line 15 (the percentage of RHC services) by the amount on line 16 (total overhead).

Line 18.--Enter the total allowable cost of RHC services. Enter the sum of line 12 (cost of RHC services other than overhead services) and line 17 (overhead services applicable to RHC services).

4612. 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 vaccine.

Line 1.--Enter the health care staff cost from Worksheet A, column 7, line 14.

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. Obtain the estimated percentage of time spent from your accounting books and records.

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 vaccines and the cost of related medical supplies from Worksheet A column 7, lines 30 and 31, in columns 1 and 2, respectively.

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

Line 6.--Enter the amount of total direct cost of the facility from Worksheet A, column 7, line 39.

Line 7.--Enter the amount from Worksheet A, column 7, line 74.

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.

Line 11.--Enter in columns 1 and 2 respectively, 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 from your records the number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries, in columns 1 and 2 respectively.

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 vaccines and administration by entering the sum of the amounts in columns 1 and 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 administration by entering the sum of the amount in columns 1 and 2, line 14. Transfer the result to Worksheet C, Part II, line 23.

4613. WORKSHEET C - DETERMINATION OF MEDICARE PAYMENT

Use this worksheet to determine the interim all inclusive rate of payment and the total Medicare payment reimbursement calculation for RHC services rendered to program patients for the reporting period.

4613.1 Part I - Determination of Rate for RHC Services.--Use Part I to calculate the cost per visit for RHC 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 18.

Line 2.--Enter the total cost of pneumococcal and influenza vaccine from 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 10.

Line 5.--Enter the visits made by physicians under agreement from Worksheet B, Part I, column 5, line 11.

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 16.--Complete columns 1 and 2 for lines 8 through 16 to identify costs and visits affected by different payment limits during a cost reporting period. The payment limits are updated every January 1. However, the possibility exists that payment limits may also be updated other than on January 1. Complete columns 1 and 2 (and if applicable add a column 3 for lines 8 through 16, if the cost reporting overlaps 3 payment limit update periods) If only one payment limit is applicable during the cost reporting period (calendar year reporting period), complete column 2 only.

Line 8.--Enter the per visit payment limit. Obtain this amount from your contractor.

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

4613.2 Part II - Determination of Total Payment.--Use Part II to determine the total Medicare payment due you for covered RHC services furnished to Medicare beneficiaries during the reporting period.

Line 10.--Enter the number of Medicare covered visits excluding mental health services. Obtain this from your contractor records. This visit count must equal the visits on Worksheet S-3, column 5, line 2.

Line 11.--Enter the subtotal of Medicare cost. This cost is determined by multiplying the rate per visit on line 9 by the number of visits on line 10 (the total number of covered Medicare beneficiary visits excluding mental health services for RHC services during the reporting period).

Line 12.--Enter the number of Medicare covered visits for mental health services. Obtain this from your contractor records. This visit count must equal the visits on Worksheet S-3, column 5, line 4.

Line 13.--Enter the Medicare covered cost for mental health services by multiplying the rate per visit on line 9 by the number of visits on line 12.

Line 14.--Enter the total Medicare cost. This is equal to the sum of the amounts on lines 11 and 13.

Line 15.--Enter the Medicare beneficiary's deductible amount. RHCs obtain this amount from the PS&R report.

Line 16.--Enter the net Medicare cost excluding pneumococcal and influenza vaccine and administration. Determine by subtracting the amount on line 15 from the amount on line 14.

NOTE: Section 4104 of ACA eliminates coinsurance and deductible for preventive services. RHCs 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 19 and 20.

Line 17.--Enter the total Medicare charges from the contractor's records (PS&R report).

Line 18.--Enter the total Medicare preventive charges from the provider's records or the PS&R report.

Line 19.--Enter the total Medicare preventive costs ((line 18 divided by line 17) times line 14)).

Line 20.--Enter the total program non-preventive costs ((line 16 minus line 19) times 80 percent)).

Line 21.--Enter the sum of lines 19 and 20.

Line 22.--Enter the total allowable GME pass-through costs determined by dividing Medicare visits (sum of Worksheet C, Part II, columns 1 and 2, lines 10 and 12) by the total visits (from Worksheet C, Part I, line 6) and multiply that result by (the sum of the total allowable GME cost reported on Worksheet A, column 7, line 29). NOTE: If Worksheet S-1, Part I, line 19, column 1 is "N", GME pass-through costs on this line must be zero.

Line 23.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 24.--Enter the primary payer amounts from the PS&R.

Line 25.--Enter the sum of lines 21, 22, and 23, minus line 24.

Line 26.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 26 and 27 will be negative.

Line 27.--Multiply the amount (including negative amounts) from line 26 by 65 percent.

Line 28.--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 26.

Line 29.--Enter the sum of lines 25 and 27.

Line 30.--Enter all demonstration payment adjustment amounts before sequestration.

Line 31.--Enter any other adjustment. If the other adjustment is an addition to costs, enter the amount as a negative. Specify the adjustment in the space provided.

Line 32.--Enter the result of line 29 minus lines 30 and 31.

Line 33.--Enter the sequestration adjustment amount as [(2 percent times line 32]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

Line 34.--Enter all demonstration payment adjustment amounts after sequestration.

Line 35.--Enter the result of line 32 minus lines 33 and 34.

Line 36.--Enter the amount of interim payments from Worksheet C-1, column 2, line 4.

Line 37.--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet C-1, column 2, line 5.99.

Line 38.--Enter the total amount due to/from the program (line 35 minus lines 36 and 37). Transfer this amount to Worksheet S, Part III, column 1, line 1.

Line 39.--Enter the Medicare reimbursement effect of protested items. Estimate the reimbursement effect of the non-allowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See 42 CFR 413.24(j)(2)(i)) Attach a schedule showing the supporting details and computations for this line.

4614. WORKSHEET C-1 - ANALYSIS OF PAYMENTS TO THE RURAL HEALTH CLINIC FOR SERVICES RENDERED

Complete lines 1 through 4 of this worksheet only for Medicare interim payments paid by the contractor. Do not complete it for purposes of reporting interim payments for titles V or XIX.

The remainder of this worksheet is completed by your contractor. All amounts reported on this worksheet must be for services rendered during the cost reporting period for which the costs are included in this cost report.

Line Descriptions

Line 1.--Enter the total Medicare interim payments paid to the RHC. The amount entered must reflect the sum of all interim payments paid on individual bills (net of adjustment bills) for services rendered in this cost reporting period. Do not include MA supplemental payments on this worksheet. The amount entered must also include amounts withheld from your interim payments due to an offset against overpayments applicable to the prior cost reporting periods. Do not include (1) any retroactive lump sum adjustment amounts based on a subsequent revision of the interim rate, (2) tentative or net settlement amounts, or (3) interim payments payable.

Line 2.--Enter the total Medicare interim payments payable on individual bills. Since the cost in the cost report is on an accrual basis, this line represents the amount of services rendered in the cost reporting period but not paid as of the end of the cost reporting period. It does not include payments reported on line 1.

Line 3.--Enter the amount of each retroactive lump sum adjustment and the applicable date.

Line 4.--Enter the total amount of the interim payments (sum of lines 1, 2, and 3.99). Transfer this amount to Worksheet C, Part II, line 36.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET C-1. LINES 5 THROUGH 8 ARE FOR CONTRACTOR USE ONLY. (EXCEPTION: IF WORKSHEET S, PART I, LINE 3 IS GREATER THAN ZERO (AMENDED COST REPORT), THE RHC MAY COMPLETE LINES 5 THROUGH 7.)

Line 5.--List separately each tentative settlement payment after the cost report is accepted together with the date of payment. If the cost report is reopened after the NPR has been issued, report all settlement payments prior to the current reopening on this line.

Line 6.--Enter the net settlement amount (balance due the RHC or balance due the program) for the NPR, or, if this settlement is after a reopening of the NPR, for this reopening. Enter in column 2 the amount from Worksheet C, Part II, line 37.

NOTE: On lines 3, 5, and 6, when an RHC to program amount is due, 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.

Line 7.--Enter the sum of the amounts on lines 4, 5.99, and 6 in column 2. Enter amounts due the program as a negative number. The amount in column 2 must equal the amount on Worksheet C, Part II, line 35.

Line 8.--Contractor approving official must verify the accuracy of this worksheet, sign and date.

EXHIBIT 1 - Form CMS-222-17

The following is a listing of the Form CMS-222-17 worksheets and the page number location.

This page is reserved for future use.

EXHIBIT 2-ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE OF CONTENTS

This page is reserved for future use.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
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 ECR files to contractors is CD, flash drive, or the CMS-approved Medicare Cost Report E-filing (MCREF) portal, [URL: https://mcref.cms.gov]. ECR files must comply with CMS specifications. Providers should seek approval from their contractors regarding the method 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
12345678901234567890123456789012345678901234567890123456789012345678901234567890
1           1   213975201727420182734A99P00120190152018273
1           2       14:30
```

Record #1: This is a cost report file submitted by Provider 213975 for the period from October 1, 2017 (2017274) through September 30, 2018 (2018273). It is filed on FORM CMS-222-17. 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 January 15, 2019 (2018015). The electronic cost report specification dated September 30, 2018 (2018273) is used to prepare this file.

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:

RFNNNNNN.YYL, where

1. RF (Rural Health Clinic Cost Report) is constant;
2. NNNNNN is the 6 digit CMS Certification 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 facility with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed

Name each cost report PI file in the following manner:

PINNNNNN.YYLC, where

1. PI (Print Image) is constant;
2. NNNNNN is the 6 digit CMS Certification 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 RHCs with two or more cost reporting periods ending in the same calendar year.
5. C is the number of times this original cost report is being filed

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Number 1

		Size	Usage	Loc.	Remarks
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 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-222-17)
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 ending on or after 20180273 (09/30/2018).

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 1 Records - Record Numbers 2 - 99

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "1"
2.	Spaces	10	X	2-11	
3.	Record Number	2	9	12-13	#3 - Vendor information; optional record for use by vendors. Left justified in positions 21 through 60. #4 - The time that the ECR file is created. This is represented in military time as alpha numeric. Use positions 21-25. Example 2:30 PM is expressed as 14:30. #3-99 - Reserved for future use.
4.	Spaces	7	X	14-20	Spaces (optional)
5.	ID Information	40	X	21-60	Left justified to position 21.

RECORD NAME: Type 2 Records for Labels

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "2"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Sub column Number	2	9	19-20	Numeric
8.	Cost Center Code	4	9	21-24	Numeric. Refer to Table 5 for appropriate cost center codes.
9.	Labels/Headings				
	a. Line Labels	36	X	25-60	Alphanumeric, left justified
	b. Column Headings Statistical Basis & Code	10	X	21-30	Alphanumeric, left justified

The type 2 records contain text which appears on the printed cost report. Of these, there are three groups: (1) Worksheet A cost center names (labels); (2) column headings for step down entries; and (3) other text appearing in various places throughout the cost report. The standard cost center labels/descriptions are listed below.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 2 Records for Labels (Cont.)

A Worksheet A cost center label must be furnished for every cost center with cost or charge data anywhere in the cost report. The line and subline numbers for each label must be the same as the line and subline numbers of the corresponding cost center on Worksheet A. The columns and subcolumn numbers are always set to zero.

Use the following type 2 cost center descriptions for Worksheet A standard cost center lines.

Line	Description
1	PHYSICIAN
2	PHYSICIAN ASSISTANT
3	NURSE PRACTITIONER
4	CERTIFIED NURSE MIDWIFE
5	REGISTERED NURSE
6	LICENSED PRACTICAL NURSE
7	CLINICAL PSYCHOLOGIST
8	CLINICAL SOCIAL WORKER
9	LABORATORY TECHNICIAN
15	PHYSICIAN SERVICES UNDER AGREEMENT
16	PHYSICIAN SUPERVISION UNDER AGREEMENT
25	MEDICAL SUPPLIES
26	TRANSPORTATION (HEALTH CARE STAFF)
27	DEPRECIATION-MEDICAL EQUIPMENT
28	MALPRACTICE PREMIUMS
29	ALLOWABLE GME COSTS
30	PNEUMOCOCCAL VACCINES & MED SUPPLIES
31	INFLUENZA VACCINES & MED SUPPLIES
40	RENT
41	INSURANCE
42	INTEREST ON MORTGAGE OR LOANS
43	UTILITIES
44	DEPRECIATION-BUILDINGS AND FIXTURES
45	DEPRECIATION-MOVABLE EQUIPMENT
46	HOUSEKEEPING AND MAINTENANCE
47	PROPERTY TAX
60	OFFICE SALARIES
61	DEPRECIATION-OFFICE EQUIPMENT
62	OFFICE SUPPLIES
63	LEGAL
64	ACCOUNTING
65	INSURANCE
66	TELEPHONE
67	FRINGE BENEFITS AND PAYROLL TAXES
75	PHARMACY
76	DENTAL
77	OPTOMETRY
78	NON-ALLOWABLE GME PASS THROUGH COSTS
79	TELEHEALTH
80	CHRONIC CARE MANAGEMENT

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

Examples of type 2 records are below. Either zeros or spaces may be used in the line, subline, column, and sub column number fields (positions 11through 20). However, spaces are preferred. Refer to Table 5 and 6 for additional cost center code requirements.

Examples:

Worksheet A line labels with embedded cost center codes:

```
2A000000    1       0100PHYSICIAN
2A00000000020000000200PHYSICIAN ASSISTANT
2A000000    9       0900LABORATORY TECHNICIAN
2A000000   25       2500MEDICAL SUPPLIES
2A000000   27       2700DEPRECIATION-MEDICAL EQUIPMENT
2A000000   40       4000RENT
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

RECORD NAME: Type 3 Records for Non Label Data

		Size	Usage	Loc.	Remarks
1.	Record Type	1	9	1	Constant "3"
2.	Wkst. Indicator	7	X	2-8	Alphanumeric. Refer to Table 2.
3.	Spaces	2	X	9-10	
4.	Line Number	3	9	11-13	Numeric
5.	Subline Number	2	9	14-15	Numeric
6.	Column Number	3	X	16-18	Alphanumeric
7.	Sub column Number	2	9	19-20	Numeric
8.	Field Data				
	a. Alpha Data	36	X	21-56	Left justified. (Y or N for yes/no answers; dates must use MM/DD/YYYY format - slashes, no hyphens.) Refer to Table 6 for additional requirements for alpha data.
		4	X	57-60	Spaces (optional).
	b. Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeros are suppressed; trailing zeros to the right of the decimal point are not. (See example below.) Positive values are presumed; no "+" signs are allowed. Use leading minus to specify negative values unless the field is defined as negative on the form. Express percentages as decimal equivalents, i.e., 8.75% is expressed as .087500. All records with zero values are dropped. Refer to Table 6 for additional requirements regarding numeric data.

A sample of type 3 records and a number line for reference are below.

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789012345678890
 3A000000   5    1              20502
 3A000000   8    1              46347
 3A000000  17    2              98469
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 1 - RECORD SPECIFICATIONS

The line numbers are numeric. In several places throughout the cost report (see list below), the line numbers themselves are data. The placement of the line and subline numbers as data must be uniform.

Worksheet A-6, columns 3 and 6
Worksheet A-8, column 4
Worksheet A-8-1, Part I, column 1

RECORD NAME: TYPE "3" RECORDS

Examples of records (*) with a Worksheet A line number as data are below.

```
                              1                   2
3                    4                    5                    6

12345678901234567890123456789012345678901234567890123456789012345678901234567890

 3A600010   1    0  NON-RHC PHYSICIAN COMPENSATION
 3A600010   1    1  AA
*3A600010   1    3              87.00
 3A600010   1    4             121656
*3A600010   1    6               1.00
 3A600010   1    7             121656

 3A800000   5    1  B
 3A800000   5    2              -1993
*3A800000   5    4              25.00

*3A810002   1    1              17.00
 3A810002   1    3  LATEX GLOVES
 3A810002   1    4                32
 3A810002   1    5               280
```

RECORD NAME: TYPE 4 RECORDS
File Encryption and Date and Time Stamp

This type 4 record consists of 3 records: 1, 1.01, and 1.02. These records are created at the point in which the ECR file has been completed and saved to disk, CD, or flash drive to insure the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 2 - WORKSHEET INDICATORS

This table contains the worksheet indicators that are used for electronic cost reporting. A worksheet indicator is provided for only those worksheets for which data are to be provided.

The worksheet indicator consists of seven digits in positions 2 through 8 of the record identifier. The first two digits of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third digit of the worksheet indicator (position 4 of the record identifier) is used to identify the part of the worksheet, e.g., worksheet A-8-1. The fourth character of the worksheet indicator (position 5 of the record identifier) is not used. For Worksheet A-6, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record identifier) identify the reclassification code. The seventh character of the worksheet indicator (position 8 of the record identifier) represents the worksheet or worksheet part.

Worksheets That Apply to the Rural Health Clinic Cost Report

Worksheet	Worksheet Indicator	
S, Part I	S000001	
S, Part II	S000002	
S, Part III	S000003	
S-1, Part I	S100001	
S-1, Part II	S100002	(a)
S-2	S200000	
S-3	S300000	
A	A000000	
A-6	A600??0	(c)
A-8	A800000	
A-8-1, Parts I & II	A810001	(b)
B, Parts I & II	B000001	(b)
B-1	B100000	
C, Parts I & II	C000001	(b)
C-1	C100000	

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Worksheet S-1, Part II for Consolidated Cost Reports
The fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate reports with one or more consolidated RHCs. For reports that do not need additional worksheets, the default is 01. For reports that do need additional worksheets, the first page is numbered 01. The number for each additional page of the worksheet is incremented by 1.

(b) Worksheets with Multiple Parts Using Identical Worksheet Indicator
Although some worksheets have multiple parts, the lines are numbered sequentially. In these instances, the same worksheet identifier is used with all lines from this worksheet regardless of the worksheet part. This differs from the Table 3 presentation, which still identifies each worksheet and part as they appear on the printed cost report. This affects Worksheets A-8-1, B, and C.

(c) Worksheet A-6
For Worksheet A-6, include in the worksheet identifier the reclassification code as the 5th and 6th digits (6th and 7th of the record). For example, 3A6000A0 or 3A6000B0, 3A6000C0, 3A600AA0, 3A600AB0, or 3A600ZZ0. Additionally, for Worksheet A-6 include in the worksheet identifier "00" in the 5th and 6th digits (6th and 7th of the record) (3A600000) to identify grand total reclassification increases and grand total reclassification decreases.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

This table identifies the collection of all data elements from all worksheets in a rural health clinic cost report. This includes data elements necessary to calculate a rural health clinic cost report, informational data, and calculated data. Calculated fields (e.g., Worksheet A, column 7) are used to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the independent rural health clinic and the report produced by the Medicare contractor. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustments required, refer to the cost report instructions.

Table 3 "Usage" column is used to specify the format of each data item as follows:

9	Numeric, greater than or equal to zero.
-9	Numeric, may be either greater than, less than, or equal to zero.
9(x).9(y)	Numeric, greater than zero, with x or fewer significant digits to the left of the decimal point, a decimal point, and exactly y digits to the right of the decimal point.
X	Character.

Consistency in line numbering (and column numbering for general service cost centers) for each cost center is essential. The sequence of some cost centers does change among worksheets.

Table 3 refers to the data elements needed from a standard cost report. When a standard line is subscripted, the subscripted lines must be numbered sequentially with the first subline number displayed as "01" or "1" (with a space preceding the 1) in field locations 14 and 5. It is unacceptable to format in a series of 10, 20, or skip subline numbers (i.e., 01, 03), except for skipping subline numbers for prior year cost center(s) deleted in the current period or initially created cost center(s) no longer in existence after cost finding. Exceptions are specified in this manual. For "Other (specify)" lines, i.e., Worksheet settlement series and any other nonstandard cost center lines, all subscripted lines should be in sequence and consecutively numbered beginning with subscripted line number 01. Automated systems should reorder these numbers where providers skip or delete a line in the series.

Drop all records with zero values from the file. Any record absent from a file is treated as if it were zero.

All numeric values are presumed positive. Leading minus signs may only appear in data with values less than zero that are specified in Table 3 with a usage of "-9". Amounts that are within preprinted parentheses on the worksheets, indicating the reduction of another number, are reported as positive values.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S	Line(s)	Column(s)	Field Size	Usage
Part I: Cost Report Status				
Provider Use Only				
Electronically filed cost report	1	1	1	X
Manually submitted cost report	2	1	1	X
If this is an amended report enter the number of times the provider resubmitted this cost report	3	1	1	X
Medicare Utilization - Enter "F" for full, "L" for low, or "N" for no utilization.	4	1	1	X
Contractor Use Only				
Cost Report Status				
Enter the cost report status code: 1 for as submitted, 2 for settled without audit, 3 settled with audit, 4 reopened, or 5 amended.	5	1	1	X
Date received (mm/dd/yyyy)	6	2	10	X
Contractor Number	7	2	5	X
Initial report for this Provider CCN	8	2	1	X
Final report for this Provider CCN	9	2	1	X
Notice of Program Reimbursement (NPR) date (mm/dd/yyyy)	10	3	10	X
Enter contractor's vendor code (ADR)	11	3	1	X
If line 5, column 1 is 4: enter the number of times reopened = 0-9	12	3	1	X
Part III: Settlement Summary				
Balances due provider or program:				
title XVIII	1	1	11	-9

WORKSHEET S-1, PART I	Line(s)	Column(s)	Field Size	Usage
Site Name	1	1	36	X
Provider CCN	1	2	6	X
CBSA	1	3	5	X
Date Certified	1	4	10	X
Type of Control	1	5	2	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-1, PART I (Cont.)	Line(s)	Column(s)	Field Size	Usage
Street	2	1	36	X
P.O. Box	2	2	9	X
City	3	1	36	X
State	3	2	2	X
Zip Code	3	3	10	X
County	3	4	36	X
Cost reporting period beginning date (MM/DD/YYYY)	4	1	10	X
Cost reporting period ending date (MM/DD/YYYY)	4	2	10	X
Is this RHC part of an entity that owns, leases or controls multiple RHCs? (Y/N). If yes, enter the entity's information below.	5	1	1	X
Name of Entity	6	1	36	X
Street	7	1	36	X
P.O. Box	7	2	9	X
HRSA Award Number	7	3	20	X
City	8	1	36	X
State	8	2	2	X
Zip Code	8	3	10	X
Is this RHC part of a chain organization as defined in §2150 of CMS Pub 15-1 that claims home office costs in a Home Office Cost Statement? (Y/N) If yes, enter the chain organization's information below.	9	1	1	X
Type of Control	9	2	2	X
Name of Chain Organization	10	1	36	X
Street	11	1	36	X
P.O. Box	11	2	9	X
Home Office CCN	11	3	6	X
City	12	1	36	X
State	12	2	2	X
Zip Code	12	3	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-1, PART I (Cont.)	Line(s)	Column(s)	Field Size	Usage
Consolidated Cost Report				
Is this RHC filing a consolidated cost report per CMS Pub. 100-02, Chapter 13, §80.2? (Y/N) 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, and subscripted lines blank.	13	1	1	X
Date Requested	13	2	10	X
Date Approved	13	3	10	X
Number of RHCs	13	4	2	X
List of Consolidated Providers	14.01-14.50	1	36	X
CCN	14.01-14.50	2	6	X
CBSA	14.01-14.50	3	5	X
Date Requested	14.01-14.50	4	10	X
Date Approved	14.01-14.50	5	10	X
Medical Malpractice				
Does this RHC carry commercial malpractice insurance? (Y/N)	15	1	1	X
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	1	1	X
List amounts of malpractice premiums in column 1, paid losses in column 2, or self insurance in column 3.	17	1-3	11	9
Are malpractice premiums, paid losses, or self insurance reported in a cost center other than the malpractice premiums cost center? (Y/N)	18	1	1	X
Miscellaneous				
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)? (Y/N)	19	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-1, PART I (Cont.)	Line(s)	Column(s)	Field Size	Usage
Have you received an approval for an exception to the productivity standard? (Y/N)	20	1	1	X
Does the facility operate as other than a RHC? (Y/N)	21	1	1	X
If line 21 is "Y", specify type of operation.	22	1	36	X
Identify days and hours by listing the time the facility operates as a RHC next to the applicable day. *				
Sunday through Saturday	23.01-23.07	1, 2	4	X
Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day. *				
Sunday through Saturday	24.01-24.07	1, 2	4	X
Did this facility participate in any payment demonstration during this cost reporting period? (Y/N)	25	1	1	X
If line 25, column 1 is yes, enter the type of demonstration in column 2.	25	2	36	X
Are there any costs included in Worksheet A that resulted from transactions with related organizations as defined in CMS Pub. 15-1, chapter 10? (Y/N) If yes, complete A-8-1.	26	1	1	X

WORKSHEET S-1, PART II	Line(s)	Column(s)	Field Size	Usage
Site Name	1	1	36	X
Date Certified	1	2	10	X
Type of Control	1	3	2	X
Date Decertified	1	4	10	X
V/I Decertification	1	5	10	X
Date of CHOW	1	6	10	X
Street	2	1	36	X
P.O. Box	2	2	9	X
City	3	1	36	X
State	3	2	2	X
Zip Code	3	3	10	X
County	3	4	36	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-1, PART II (Cont.)	Line(s)	Column(s)	Field Size	Usage
Medical Malpractice				
Does this RHC carry commercial malpractice insurance? (Y/N)	4	1	1	X
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	1	1	X
List amounts of malpractice premiums in column 1, paid losses in column 2, or self insurance in column 3.	6	1-3	11	X
Miscellaneous				
Does the facility operate as other than a RHC? Enter "Y" for yes and "N" for no.	7	1	1	X
If line 7 is "Y", specify type of operation (i.e. physician's office, independent laboratory etc.)	8	1	36	X
Identify days and hours by listing the time the facility operates as a RHC next to the applicable day. *				
Sunday through Saturday	9.01-9.07	1, 2	4	X
Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day. *				
Sunday through Saturday	10.01-10.07	1, 2	4	X

* Enter the time based on a 24 hour clock. For example 8:30 am is 0830 and 5:00 pm is 1700.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-2	Line(s)	Column(s)	Field Size	Usage
Provider Organization and Operation				
Has the RHC changed ownership immediately prior to the beginning of the cost reporting period? (Y/N)	1	1	1	X
If yes, enter the date of the change in column 2. (mm/dd/yyyy)	1	2	10	X
Has the RHC terminated participation in the Medicare program? (Y/N)	2	1	1	X
If yes, enter in column 2 the date of termination. (mm/dd/yyyy)	2	2	10	X
If yes, enter in column 3 "V" for voluntary or "I" for involuntary.	2	3	1	X
Is the RHC involved in business transactions, including management contracts, with individuals or entities that were 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? (Y/N)	3	1	1	X
Financial Data Reports				
Were the financial statements prepared by a certified public accountant? (Y/N)	4	1	1	X
If yes, enter in column 2 "A" for audited, "C" for compiled or "R" for reviewed.	4	2	1	X
Submit a complete copy of financial statements or enter date available in column 3. (mm/dd/yyyy)	4	3	10	X
Are the cost report total expenses and total revenues different from those on the filed financial statements? (Y/N)	4	4	1	X
Approved Educational Activities				
Are costs for Intern-Resident programs claimed on the current cost report? (Y/N)	5	1	1	X
Was an Intern-Resident program initiated or renewed in the current cost reporting period? (Y/N)	6	1	1	X
Are GME costs directly assigned to cost centers other than Allowable GME Costs on Worksheet A? (Y/N)	7	1	1	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-2 (Cont.)	Line(s)	Column(s)	Field Size	Usage
Bad Debts				
Is the RHC seeking reimbursement for bad debts? (Y/N)	8	1	1	X
If line 8 is yes, did the RHC's bad debt collection policy change during the cost reporting period? (Y/N)	9	1	1	X
If line 8 is yes, were patient coinsurance amounts waived? (Y/N)	10	1	1	X
PS&R Report Data				
Was the cost report prepared using the PS&R Report only? (Y/N)	11	1	1	X
If yes, enter in column 2 the paid-through date of the PS&R Report used to prepare the cost report. (mm/dd/yyyy)	11	2	10	X
Was the cost report prepared using the PS&R Report for totals and the RHC's records for allocation? (Y/N)	12	1	1	X
If yes, enter in column 2 the paid-through date of the PS&R Report. (mm/dd/yyyy)	12	2	10	X
If line 11 or 12 is yes, were adjustments made to the 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? (Y/N)	13	1	1	X
If line 11 or 12 is yes, were adjustments made to the PS&R Report data for corrections of other PS&R Report information? (Y/N)	14	1	1	X
If line 11 or 12 is yes, describe the other adjustments.	15	0	36	X
If line 11 or 12 is yes, were adjustments made to the PS&R Report data for Other? (Y/N)	15	1	1	X
Was the cost report prepared only using the RHC's records? (Y/N)	16	1	1	X
Cost Report Preparer Contact Information				
Enter the preparer's information:				
First Name	17	1	36	X
Last Name	17	2	36	X
Title	17	3	36	X
Employer	18	1	36	X
Phone Number	19	1	36	X
Email Address	19	2	36	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET S-3	Line(s)	Column(s)	Field Size	Usage
Rural Health Clinic Statistical Data				
Use this column only when filing a consolidated cost report to identify each RHC listed on Worksheet S-1, Part I, line 14, and subscripts in the exact same order.	1, 3, 5	0	6	X
Title V: enter the number of medical visits, mental health visits, and visits performed by interns/residents.	1-6	1	11	9
Title XVIII: enter the number of medical visits, mental health visits, and visits performed by interns/residents.	1-6	2	11	9
Title XIX: enter the number of medical visits, mental health visits, and visits performed by interns/residents.	1-6	3	11	9
Enter the number of medical visits, mental health visits, and visits performed by interns/residents for all other patients.	1-6	4	11	9
Total All Patients	1-6	5	11	9
Total Visits	7	5	11	9

WORKSHEET A	Line(s)	Column(s)	Field Size	Usage
Salaries	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	1	11	-9
Other Costs	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	2	11	-9
Total	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	3	11	-9
Reclassifications	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	4	11	-9
Reclassified Trial Balance	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	5	11	-9
Adjustments	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	6	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET A (Cont.)	Line(s)	Column(s)	Field Size	Usage
Net Expenses For Allocation	1-10, 15-16, 25-32, 40-48, 60-68, 75-81, 87-89	7	11	-9
Subtotal	14, 17, 38, 59, 73, 86, 90	1-7	11	-9
Total Cost of Services	39	1-7	11	-9
Total Overhead	74	1-7	11	-9
Total Costs	100	1-7	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET A-6	Line(s)	Column(s)	Field Size	Usage
For each expense reclassification:				
Explanation	1-99	0	36	X
Code	1-99	1	2	X
Increases:				
Worksheet A line number	1-99	3	5	99.99
Reclassification amount	1-99	4	11	9
Decreases:				
Worksheet A line number	1-99	6	5	99.99
Reclassification amount	1-99	7	11	9
Total	100[#]	4 & 7	11	9
Total Reclassification Increases	100[#]	4	11	9
Total Reclassification Decreases	100[#]	7	11	9

WORKSHEET A-8	Line(s)	Column(s)	Field Size	Usage
Description of adjustment	14-49	0	36	X
Basis (A or B) *	1-6, 8-49	1	1	X
Amount *	1-49	2	9	-9
Cost Center	3-6, 8-10, 14-49	3	36	X
Worksheet A line number +	3-6, 8-10, 14-49	4	5	99.99
Total	50	2	11	-9

* These include subscripts of lines 14 through 49, requiring records for columns 1 and 2.
+ Do not include preprinted lines 1, 2, 11, 12, & 13. Include only subscripts of those lines, if activated by an entry in either of columns 1 or 2.
[#] See footnote “b” in “Table 2 - Worksheet Indicators” for appropriate worksheet indicators.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET A-8-1	Line(s)	Column(s)	Field Size	Usage
Part I - Costs incurred and adjustments required as a result of transactions with related organizations or claimed home office costs				
Worksheet A line number	1-4	1	5	99.99
Cost center	1-4	2	36	X
Expense item(s)	1-4	3	36	X
Amount of allowable cost	1-4	4	11	-9
Amount included in Worksheet A	1-4	5	11	-9
Net Adjustments	1-4	6	11	-9
Total	5	4-6	11	-9
Part II - For each related organization				
Type of interrelationship (A through G)	6-10	1	1	X
If type is G, description of relationship must be included	6-10	0	36	X
Name of individual or partnership with interest in provider and related organization	6-10	2	36	X
Percentage of ownership in provider	6-10	3	6	9 (3).99
Name of related individual or organization	6-10	4	36	X
Percentage of ownership of provider	6-10	5	6	9(3).99
Type of business	6-10	6	36	X

WORKSHEET B, PART I	Line(s)	Column(s)	Field Size	Usage
Position by department:				
Number of FTE personnel	1-10	1	6	9(3).99
Total Visits	1-11	2	11	9
Productivity Standard	1-4	3	11	9
Minimum Visits	1-5	4	11	9
Greater of columns 2 or 4	5-11	5	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET B, PART II	Line(s)	Column(s)	Field Size	Usage
Cost of RHC service - excluding overhead and allowable GME costs	12	1	11	9
Cost of other than RHC - excluding overhead	13	1	11	9
Cost of all services - excluding overhead	14	1	11	9
Ratio of RHC	15	1	11	9
Total Overhead	16	1	11	9
Overhead applicable to RHC Services	17	1	11	9
Total allowable cost of RHC services	18	1	11	9

WORKSHEET B-1	Line(s)	Column(s)	Field Size	Usage
Health care staff cost	1	1, 2	11	9
Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	2	1, 2	8	9.9(6)
Pneumococcal and influenza vaccine health care staff cost	3	1, 2	11	9
Vaccines and related medical supplies cost	4	1, 2	11	9
Direct cost of pneumococcal and influenza vaccine	5	1, 2	11	9
Total direct cost of the facility	6	1, 2	11	9
Total facility overhead	7	1, 2	11	9
Ratio of pneumococcal and influenza vaccine direct cost to total direct cost	8	1, 2	8	9.9(6)
Overhead cost - pneumococcal and influenza vaccine	9	1, 2	11	9
Total pneumococcal and influenza vaccine cost and administration	10	1, 2	11	9
Total number of pneumococcal and influenza vaccine injections	11	1, 2	11	9
Cost per pneumococcal and influenza vaccine injection	12	1, 2	11	9
Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1, 2	11	9
Medicare cost of pneumococcal and influenza vaccine and administration	14	1, 2	11	9
Total cost of pneumococcal and influenza vaccine and administration	15	2	11	9
Total Medicare cost of pneumococcal and influenza vaccine and administration	16	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET C, PART I	Line(s)	Column(s)	Field Size	Usage
Total allowable costs	1	1	11	9
Cost of pneumococcal and influenza vaccine and administration	2	1	11	9
Total allowable cost excluding pneumococcal and influenza vaccine	3	1	11	9
Greater of minimum visits or actual visits by health care staff	4	1	11	9
Physicians visits under agreements	5	1	11	9
Total adjusted visits	6	1	11	9
Adjusted cost per visit	7	1	11	9
Maximum rate per visit	8	1, 2	6	9(3).99
Rate for Medicare covered visits	9	1, 2	6	9(3).99

WORKSHEET C, PART II	Line(s)	Column(s)	Field Size	Usage
Medicare covered visits excluding mental health services	10	1, 2	11	9
Medicare costs excluding costs for mental health services	11	1, 2	11	9
Medicare covered visits for mental health services	12	1, 2	11	9
Medicare covered cost for mental health services	13	1, 2	11	9
Total Medicare cost	14	1, 2	11	9
Less: beneficiary deductible	15	1, 2	11	9
Net Medicare cost excluding pneumococcal and influenza vaccine and administration	16	1, 2	11	9
Total Medicare charges	17	1	11	9
Total Medicare preventive charges	18	1	11	9
Total Medicare preventive costs	19	1	11	9
Total Medicare non-preventive costs	20	1	11	9
Net Medicare cost	21	1	11	9
Graduate medical education pass through cost	22	1	11	9
Medicare cost of pneumococcal and influenza vaccine and administration	23	1	11	9
Primary payer payments	24	1	11	9
Net Medicare reimbursement excluding bad debts	25	1	11	9
Allowable bad debts	26	1	11	9
Adjusted reimbursable bad debts	27	1	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

WORKSHEET C, PART II (Cont.)	Line(s)	Column(s)	Field Size	Usage
Allowable bad debts for dual eligible beneficiaries	28	1	11	9
Subtotal	29	1	11	9
Other demonstration payment adjustment amount before sequestration	30	1	11	-9
Other adjustments (specify)	31	1	11	-9
Amount due RHC prior to sequestration adjustment	32	1	11	9
Sequestration adjustment	33	1	11	9
Other demonstration payment adjustment amount after sequestration	34	1	11	-9
Amount due RHC after sequestration adjustment	35	1	11	9
Interim payments	36	1	11	-9
Tentative Settlement	37	1	11	-9
Balance due RHC/program	38	1	11	-9
Protested amounts	39	1	11	-9

WORKSHEET C-1	Line(s)	Column(s)	Field Size	Usage
Total interim payments paid to RHC	1	2	11	9
Interim payments payable	2	2	11	9
Date of each retroactive lump sum adjustment (mm/dd/yyyy)	3.01-3.98	1	10	X
Amount of each retroactive lump sum adjustment:				
Program to provider	3.01-3.49	2	11	9
Provider to Program	3.50-3.98	2	11	9
Subtotal	3.99	2	11	9
Total interim payments	4	2	11	9
Date of the tentative payment from Program to Provider (mm/dd/yyyy)	5.01-5.98	1	10	X
Amount of tentative payment:				
Program to provider	5.01-5.49	2	11	9
Provider to Program	5.50-5.98	2	11	9
Subtotal	5.99	2	11	9
Date of the net settlement amount (mm/dd/yyyy)	6.01-6.02	1	10	X
Net settlement amount Program to provider	6.01	2	11	9
Net settlement amount provider to Program	6.02	2	11	9
Total Medicare program liability	7	2	11	9
Enter the date of the NPR	8	1	11	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

All Worksheets require input

TABLE 3B - TABLE TO WORKSHEET S-1, PARTS I AND II

Type of Control:

1 = Voluntary Nonprofit, Corporation
2 = Voluntary Nonprofit, Other
3 = Proprietary, Individual
4 = Proprietary, Corporation
5 = Proprietary, Partnership
6 = Proprietary, Other
7 = Government, Federal
8 = Government, State
9 = Government, County
10 = Government, City
11 = Government, Other

TABLE 3C - LINES THAT CANNOT BE SUBSCRIPTED (BEYOND THOSE PREPRINTED)

Worksheet S, Part I: All
Worksheet S, Part III: All
Worksheet S-1, Part I: lines 1-13, and 15-26
Worksheet S-1, Part II: lines 1-10
Worksheet S-2: ALL
Worksheet S-3: 2, 4, 6, and 7
Worksheet A: lines 1-9, 14, 15-17, 25-31, 38-47, 59-67, 73-80, 86, 90, and 100
Worksheet A-6: lines 1-99, and 100
Worksheet A-8: lines 1-13, and 50
Worksheet A-8-1, Part I: line 5
Worksheet A-8-1, Part II: line 10
Worksheet B-Part I: All
Worksheet B-Part II: All
Worksheet B-1: All
Worksheet C, Part I: All
Worksheet C, Part II: 10-30, and 32-39
Worksheet C-1: lines 1, 2, 4, and 6-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PROGRAMMERS

Cost center coding is required because there are thousands of unique cost center names in use by providers. Many of these names are peculiar to the reporting provider and give no hint as to the actual function being reported. Using codes to standardize meanings makes practical data analysis possible. The method to accomplish this must be rigidly controlled to assure accuracy.

For any added cost center names (the preprinted cost center labels must be pre-coded), the preparer must be presented with the allowable choices for that line or range of lines from the lists of standard and nonstandard descriptions. They then select a description that best matches their added label. The code associated with the matching description, including increments due to choosing the same description more than once, will then be appended to the user's label by the software.

Additional guidelines are:

- Any pre-existing codes for the line must not be allowed to carry over.
- All "Other . . ." lines must not be pre-coded.
- The order of choice is standard first, followed by specific nonstandard, and lastly, the nonstandard "Other . . ." cost centers.
- When the nonstandard "Other . . ." is chosen, the preparer must be prompted with "Is this the most appropriate choice?" and offered a chance to answer yes or to select another description.
- The cost center coding process must be able to be edited for purposes of making corrections.
- A separate list showing the preparer's added cost center name on the left with the chosen standard or nonstandard description and code on the right must be printed for review.
- The number of times a description can be selected on a given report must be displayed on the screen next to the description and this number must decrease with each usage to show the remaining number available. The number of times a description can be selected is shown on the standard and nonstandard cost center tables.
- Standard cost center lines, descriptions, and codes are not to be changed. The acceptable format for these are displayed in the STANDARD COST CENTER DESCRIPTIONS AND CODES listed on page 46-530. The proper line number is the first two digits of the cost center code. Change all "Other" nonstandard lines to the appropriate cost center name.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 5 - COST CENTER CODING

INSTRUCTIONS FOR PREPARERS

Coding of Cost Center Labels

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by the RHC on the Medicare cost report. The use of this coding methodology allows the RHC to use their labels for cost centers that have meaning within the institution.

The four digit codes are required and must be associated with each cost center label/description. The codes provide standardized meaning for data analysis. The preparer must code all added cost center labels/descriptions. Standard cost center labels/descriptions are automatically coded by CMS approved cost report software.

Additional cost center descriptions have been identified through analysis of provider labels. The meanings of these additional descriptions were sufficiently different when compared to the standard labels to warrant their use. These additional descriptions are hereafter referred to as the nonstandard labels. Included with the nonstandard descriptions are "Other . . ." designations to provide for situations where no match in meaning can be found. Refer to Worksheet A, lines 10, 32, 48, 68, and 81. Both the standard and nonstandard cost center descriptions, along with their cost center codes, are shown on Table 5. The "USE" column on that table indicates the number of times that a given code can be used on one cost report. Compare your added cost center labels/descriptions to the standard and nonstandard table and select the appropriate cost center code. CMS approved software provides an automated process for selecting an appropriate code to properly match with your added cost center label/description.

Additional Guidelines

Categories

You must make your selection from the proper category such as general service description for general service cost center lines, nonreimbursable descriptions for nonreimbursable cost center lines, etc.

Cost Center Coding and Line Restrictions

Cost center codes may only be used in designated lines in accordance with the classification of the cost center(s), i.e., lines 1 through 10 may only contain cost center codes within the facility health care staff costs category of both standard and nonstandard coding. For example, in the facility health care staff costs category for "Other (specify)" cost, line 10 and subscripts must contain cost center codes of 1000 through 1019 which are identified as nonstandard cost center codes. This logic must hold true for all other cost center categories, i.e., other health care costs, other than RHC services, and nonreimbursable cost centers.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
FACILITY HEALTH CARE STAFF COSTS		
Physician	0100	(01)
Physician Assistant	0200	(01)
Nurse Practitioner	0300	(01)
Certified Nurse Midwife	0400	(01)
Registered Nurse	0500	(01)
Licensed Practical Nurse	0600	(01)
Clinical Psychologist	0700	(01)
Clinical Social Worker	0800	(01)
Laboratory Technician	0900	(01)
COSTS UNDER AGREEMENT		
Physician Services Under Agreement	1500	(01)
Physician Supervision Under Agreement	1600	(01)
OTHER HEALTH CARE COSTS		
Medical Supplies	2500	(01)
Transportation (Health Care Staff)	2600	(01)
Depreciation-Medical Equipment	2700	(01)
Malpractice Premiums	2800	(01)
Allowable GME Costs	2900	(01)
Pneumococcal Vaccines & Med Supplies	3000	(01)
Influenza Vaccines & Med Supplies	3100	(01)
FACILITY OVERHEAD-FACILITY COST		
Rent	4000	(01)
Insurance	4100	(01)
Interest on Mortgage or Loans	4200	(01)
Utilities	4300	(01)
Depreciation-Building and Fixtures	4400	(01)
Depreciation-Equipment	4500	(01)
Housekeeping and Maintenance	4600	(01)
Property Tax	4700	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
FACILITY OVERHEAD-ADMINISTRATIVE COSTS		
Office Salaries	6000	(01)
Depreciation-Office Equipment	6100	(01)
Office Supplies	6200	(01)
Legal	6300	(01)
Accounting	6400	(01)
Insurance	6500	(01)
Telephone	6600	(01)
Fringe Benefits and Payroll Taxes	6700	(01)
COSTS OTHER THAN RHC SERVICES		
Pharmacy	7500	(01)
Dental	7600	(01)
Optometry	7700	(01)
Non-allowable GME Pass Through Costs	7800	(01)
Telehealth	7900	(01)
Chronic Care Management	8000	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
FACILITY HEALTH CARE STAFF COSTS		
Other Facility Health Care Staff Costs (specify)	1000	(20)
OTHER HEALTH CARE COSTS		
Other Health Care Costs (specify)	3200	(20)
FACILITY OVERHEAD-FACILITY COSTS		
Other Facility Overhead-Facility Costs (specify)	4800	(20)
FACILITY OVERHEAD-ADMINISTRATIVE COSTS		
Other Facility Overhead-Administrative Costs (specify)	6800	(20)
COSTS OTHER THAN RHC SERVICES		
Other Than RHC Service Costs (specify)	8100	(20)
NON-REIMBURSABLE COSTS		
Other Non-reimbursable Costs (specify)	8700	(20)
Other Non-reimbursable Costs (specify)	8800	(20)
Other Non-reimbursable Costs (specify)	8900	(20)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Medicare cost reports submitted electronically must meet a variety of edits. These include mathematical accuracy edits, certain minimum file requirements, and other data edits. Any vendor software which produces an electronic cost report file for Medicare RHCs 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 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 submitted by a provider containing a Level 1 edit will be rejected by the contractors. Notification must be made to CMS for any exceptions.

The edits are applied at two levels. Level 1 edits (1000 series reject codes) test the format of the data to identify error conditions that must be corrected or they will result in a cost report rejection. These edits also test for critical data elements specified in Table 3. Vendor programs must prevent RHCs from generating an electronic cost report (ECR) file when the cost report violates any Level 1 edits. Level 2 edits (2000 series edit codes) identify potential inconsistencies and missing data items. These items should be resolved at the RHC site and supporting documentation (such as worksheets or data) should be submitted with the cost report.

The vendor requirements (above) and the edits (below) reduce both contractor processing time and unnecessary rejections. Vendors must develop their programs to prevent their client RHCs from generating an ECR file where Level 1 edit conditions exist. In addition, ample warnings should be given to the RHC where Level 2 edit conditions are violated.

Level 1 edit conditions are to be applied against title XVIII services only. However, any inconsistencies or omissions that would cause a Level 1 condition for non-title XVIII services must be resolved prior to acceptance of the cost report. [09/30/2018]

NOTE: The date in brackets [ ] at the end of each edit indicates the effective date of the edit. A date without an alpha suffix, such as [09/30/2018], indicates the edit is effective for cost reporting periods ending on or after the date in brackets. A date followed by a "b," such as [09/30/2018b], indicates the edit is effective for cost reporting periods beginning on or after the date in brackets. A date followed by an "s," such as [09/30/2018s], indicates the edit is effective for services rendered on or after the date in brackets.

I. Level 1 Edits (Minimum File Requirements)

Edit	Condition
1000	The first digit of every record must be either 1, 2, 3, or 4 (encryption code only). [09/30/2018]
1005	No record may exceed 60 characters. [09/30/2018]
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. [09/30/2018]
1015	For micro systems, the end of record indicator must be a carriage return and line feed, in that sequence. [09/30/2018]
1020	The RHC facility provider number (record #1, positions 17 through 22) must be valid and numeric (issued by the applicable certifying agency and falls within the specified range). [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit **Condition**

1025 All calendar format dates must be edited for 10 character format, e.g., 01/01/2017 (MM/DD/YYYY). [09/30/2018]

1030 All dates (record #1, positions 23 through 29, 30 through 36, 45 through 51, and 52 through 58) must be in Julian format and legitimate. [09/30/2018]

1035 The fiscal year beginning date (record #1, positions 23 through 29) must be less than the fiscal year ending date (record #1, positions 30 through 36). [09/30/2018]

1036 The fiscal year ending date (record #1, positions 30 through 36) must be 30 days greater than the fiscal year beginning date (record #1, positions 23 through 29) and the fiscal year ending date (record #1, positions 30 through 36) must be less than 458 days greater than the fiscal year beginning date (record #1, positions 23 through 29). [09/30/2018]

1040 The vendor code (record #1, positions 38 through 40) must be a valid code. [09/30/2018]

1045 The type 1 record #1 must be correct and the first record in the file. [09/30/2018]

1050 All record identifiers (positions 1 through 20) must be unique. [09/30/2018]

1055 Only a Y or N is valid for fields which require a Yes/No response. [09/30/2018]

1065 All line, sub line, column, and sub column numbers (positions 11 through 13, 14 through 15, 16 through 18, and 19 through 20, respectively) must be numeric. [09/30/2018]

1067 The cost center code (positions 21-24) (type 2 records) must be a code from Table 5, cost center coding, and each cost center code must be unique. [09/30/2018]

1070 The standard cost centers listed below must be reported on the lines as indicated and the corresponding cost center codes may only appear on the lines as indicated. No other cost center codes may be placed on these lines or subscripts of these lines, unless indicated herein. [09/30/2018]

Cost Center	Line	Code
Physician	1	0100
Physician Assistant	2	0200
Nurse Practitioner	3	0300
Certified Nurse Midwife	4	0400
Registered Nurse	5	0500
Licensed Practical Nurse	6	0600
Clinical Psychologist	7	0700
Clinical Social Worker	8	0800
Laboratory Technician	9	0900
Physician Services Under Agreement	15	1500
Physician Supervision Under Agreement	16	1600
Medical Supplies	25	2500

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit **Condition**

Cost Center	Line	Code
Transportation (Health Care Staff)	26	2600
Depreciation-Medical Equipment	27	2700
Malpractice Premiums	28	2800
Allowable GME Costs	29	2900
Pneumococcal Vaccine & Med Supplies	30	3000
Influenza Vaccines & Med Supplies	31	3100
Rent	40	4000
Insurance	41	4100
Interest on Mortgage or Loans	42	4200
Utilities	43	4300
Depreciation-Buildings and Fixtures	44	4400
Depreciation-Movable Equipment	45	4500
Housekeeping and Maintenance	46	4600
Property Tax	47	4700
Office Salaries	60	6000
Depreciation- Office Equipment	61	6100
Office Supplies	62	6200
Legal	63	6300
Accounting	64	6400
Insurance	65	6500
Telephone	66	6600
Fringe Benefits and Payroll Taxes	67	6700
Pharmacy	75	7500
Dental	76	7600
Optometry	77	7700
Non-allowable GME Pass Through Costs	78	7800
Telehealth	79	7900
Chronic Care Management	80	8000

1075 Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [09/30/2018]

1080 Every line used on Worksheet A, there must be a corresponding type 2 record. [09/30/2018]

1085 Fields requiring numeric data (days, costs, FTEs, etc.) may not contain any alpha character. [09/30/2018]

1090 A numeric field cannot exceed more than 11 positions. [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit	Condition
1095	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. [09/30/2018]
1100	All dates must be possible, e.g., no "00", no "30", or "31" of February. [09/30/2018]
1000S	The RHC facility name, address, provider number, and certification date (Worksheet S-1, Part I, line 1, column 1(name); line 2, column 1 (street address); line 3, columns 1 (city), 2 (State), 3 (ZIP code), 4 (county); and line 1, column 4 (certification date), respectively) must be present and valid. [09/30/2018]
1002S	Worksheet S-1, Part I, column 3, line 1 must be completed with a valid five-position alphanumeric CBSA code. [09/30/2018]
1005S	The cost report beginning date (Worksheet S-1, Part I, column 1, line 4) must be on or after October 1, 2017. [09/30/2018]
1010S	The type of control (Worksheet S-1, Part I, column 5, line 1) must have a value of 1 through 11. (See Table 3B.) [09/30/2018]
1020S	The cost report period beginning date (Worksheet S-1, Part I, column 1, line 4) must precede the cost report ending date (Worksheet S-1, Part I, column 2, line 4). [09/30/2018]
1030S	The RHC CCN reported on Worksheet S-1, Part I, column 2, line 1, and column 2, line 14, beginning with subscripted line 14.01 must be between XX-3800 through XX-3974, or XX-8900 through XX-8999, where XX corresponds to the two digit state code. [09/30/2018]
1035S	On Worksheet S-1, Part I, there must be a "Y" or "N" response for: **Column 1**: lines 5, 9, 13, 15, 18, 19, 21, 25, and 26. [09/30/2018]
1040S	If Worksheet S-1, Part I, line 5, is "Y", then Worksheet S-1, Part I, columns 1, 2, and 3, as applicable, lines 6 through 8, must be present and valid and vice versa. Conversely, if Worksheet S-1, Part I, line 5 is "N", then Worksheet S-1, Part I, columns 1, 2, and 3, as applicable, lines 6 through 8 must be blank. [09/30/2018]
1060S	If Worksheet S-1, Part I, line 9, is "Y", then Worksheet S-1, Part I, columns 1, 2, and 3, as applicable, lines 10 through 12, must be present and valid and vice versa. Conversely, if Worksheet S-1, Part I, line 9 is "N", then Worksheet S-1, Part I, columns 1, 2, and 3, as applicable, lines 10 through 12 must be blank. [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit	Condition
1065S	On Worksheet S-1, Part I, there must be an entry on at least one of the subscripted lines 23.02 through 23.06, in columns 1 and 2; and if Worksheet S-1, Part I, column 1, line 21, is "Y", then there must be an entry on at least one of the subscripted lines 24.01 through 24.07, in columns 1 and 2. [09/30/2018]

NOTE: The edits that correspond to Worksheet S-1, Part II, are only applied if Worksheet S-1, Part II, is completed for consolidated RHCs.

1100S	If Worksheet S-1, Part I, column 1, line 13 is "Y", then column 4 must contain a number greater than or equal to 1, for the number of consolidated RHCs and if Worksheet S-1, Part I, column 4, line 1, is on or after 10/01/2017, column 2, line 13, must contain a date of request, and column 3, line 13, must contain the date of approval. If Worksheet S-1, Part I, column 4, line 13 is greater than or equal to 1, then column 1, must be "Y". If Worksheet S-1, column 1, line 13 is "N", then Worksheet S-1, Part I, line 13, columns 2, 3, and 4 and Worksheet S-1, Part I, line 14 must be blank and no subscripting. [09/30/2018]
1110S	If Worksheet S-1, Part I, column 1, line 13 is "Y", then line 14, beginning with subscripted line 14.01, for each RHC must contain: the RHC site name in column 1, the RHC CCN in column 2, and the CBSA code in column 3. If the applicable Worksheet S-1, Part II, column 2, line 1, is on or after 10/01/2017, then Worksheet S-1, Part I, line 14, beginning with subscripted line 14.01, must contain the date of request in column 4, and the date of approval in column 5. If Worksheet S-1, Part I, column 1, line 13 is "N", line 14, beginning with subscripted line 14.01, must be blank. [09/30/2018]
1170S	If Worksheet S-1, Part I, line 15 is "Y", then line 16 must contain a "1" or "2", and line 17, sum of columns 1 through 3, must be greater than zero, and vice versa. [09/30/2018]
1240S	If Worksheet S-1, Part I, any of lines 14.01 through 14.99, has an entry, then the corresponding Worksheet S-1, Part II, lines 1 through 3 must contain an entry for each RHC: the RHC site name in column 1, line 1; the RHC street address in column 1, line 2; the RHC city name in column 1, line 3; the RHC ZIP code (formatted as XXXXX) or the RHC ZIP+4 code (formatted as XXXXX-XXXX) in column 3, line 3; the RHC county name in column 4, line 3. [09/30/2018]
1250S	For each consolidated RHC entered on Worksheet S-1, Part II, column 1, line 1, there must be a corresponding value of 1 through 11 entered in column 3 for the type of control. (See Table 3B.) [09/30/2018]
1300S	If Worksheet S-1, Part I, column 1, line 13 is "Y", for each consolidated RHC identified on Worksheet S-1, Part I, column 2, lines 14.01 through 14.99, there must be a "Y" or "N" response on each applicable Worksheet S-1, Part II for: **Column 1**: lines 4 & 7. [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit	Condition
1305S	If Worksheet S-1, Part I, column 1, line 13 is "Y", then on Worksheet S-1, Part II, there must be an entry on at least one of the subscripted lines 9.02 through 9.06, in columns 1 and 2; and if Worksheet S-1, Part II, column 1, line 7, is "Y", then there must be an entry on at least one of the subscripted lines 10.01 through 10.07, in columns 1 and 2. [09/30/2018]
1340S	If Worksheet S-1, Part II, line 4 is "Y", then line 5 must contain a "1" or "2", and line 6, sum of columns 1 through 3, must be greater than zero, and vice versa. [09/30/2018]
1400S	On Worksheet S-2, there must be a "Y" or "N" response for: **Column 1**: lines 1 through 8, 11, 12, and 16. If column 1, line 8, is "Y", then column 1, lines 9 and 10, must be "Y" or "N". If column 1, lines 11 or 12, is "Y", then column 1, lines 13, 14, and 15 must be "Y" or "N". **Column 4**: line 4. [09/30/2018]
1405S	If Worksheet S-2, column 1, line 1 is "Y", then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [09/30/2018]
1410S	If Worksheet S-2, column 1, line 2 is "Y", then column 2 must contain a valid date (MM/DD/YYYY) and column 3 must contain a "V" or an "I", and vice versa. [09/30/2018]
1420S	If Worksheet S-2, column 1, line 3 is "N", then Worksheet A-8-1 must not be present. [09/30/2018]
1430S	If Worksheet S-2, column 1, line 3 is "Y", then Worksheet A-8-1, Part I, columns 4 or 5, sum of lines 1 through 4 must not equal zero, and Worksheet A-8-1, Part II, column 1, any one of lines 6 through 10 must contain one of the alpha characters A, B, C, D, E, F, or G. [09/30/2018]
1440S	If Worksheet S-2, column 1, line 4 is "Y", then column 2 must be "A", "C" or "R". If Worksheet S-2, column 1, line 4 is "N", then column 2 must be blank. [09/30/2018]
1450S	Worksheet S-3, columns 1 through 4, lines 1 through 6, must be equal to or greater than zero. [09/30/2018]
1460S	If Worksheet S-1, Part I, column 2, any of lines 14.01 through 14.99, has an entry, then Worksheet S-3, Part I, column 0, for lines 1.01 through 1.99, 3.01 through 3.99, and 5.01 through 5.99 must contain a corresponding CCN in the exact same order. [09/30/2018]
1470S	If Worksheet S-2, column 1, line 11 is "Y", then column 2 must contain a valid date (MM/DD/YYYY) and vice versa. [09/30/2018]
1480S	If Worksheet S-2, column 1, line 12 is "Y", then column 2 must contain a valid date (MM/DD/YYYY) and vice versa. [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit	Condition
1000A	All amounts reported on Worksheet A, columns 1, 2, and 7, line 100, must be greater than or equal to zero. [09/30/2018]
1020A	For reclassifications reported on Worksheet A-6 the sum of all increases (column 4) must equal the sum of all decreases (column 7). [09/30/2018]
1025A	For each line on Worksheet A-6, when an entry is present in column 4, there must be an entry in columns 1 and 3, and if an entry is present in column 7, then there must be an entry in columns 1 and 6. All entries in column 1 must be upper case alpha characters. [09/30/2018]
1032A	Worksheet A-6, column 0 must have an explanation present on the first line for each reclassification code. [09/30/2018]
1040A	For Worksheet A-8 adjustments on lines 3 through 6 and 8 through 10, if column 2 has an amount, then column 1 must be either "A" or "B", and column 4 for that line must have an entry, and if lines 14 through 49, column 2 have entries, then columns 0, 1, and 4, for the corresponding line must have entries. [09/30/2018]
1042A	For Worksheet A-8 adjustments on lines 1, 2, 11, 12, and 13, if column 2 has an entry, then column 1 of the corresponding lines must be either "A" or "B". [09/30/2018]
1045A	Worksheet A-8-1, Part I, columns 1 and 3, must have an entry when there is an amount in column 4 or 5 for each of lines 1 through 4. [09/30/2018]
1060A	For each amount on Worksheet A, column 7, lines 1, 2, 3, 4, 5, 6, 7, and 8, if the amount is greater than zero, then the corresponding FTEs and total visits on worksheet B, Part I, columns 1 and 2, must also be greater than zero and vice versa. [09/30/2018]
1065A	If the amount on Worksheet A, column 7, line 15 (Physician Services Under Agreement) is greater than zero, then the corresponding total visits on worksheet B, Part I, column 2, line 11, must also be greater than zero and vice versa. [09/30/2018]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-222-17
TABLE 6 - EDITS

Edit	Condition
1000B	Total visits on Worksheet B, Part I (sum of column 2, lines 1 through 4, 6 through 9, & 11), must be greater than or equal to the sum of the total Medicare covered visits on Worksheet C, Part II, lines 10 and 12, columns 1 and 2. [09/30/2018]
1000C	Worksheet C, Part II, line 18, must be less than or equal to line 17. [09/30/2018].

II. Level 2 Edits (Potential Rejection Errors)

These conditions are usually, but not always, incorrect. These edit errors should be cleared when possible through the cost report. When corrections on the cost report are not feasible, provide additional information in schedules, note form, or any other manner as may be required by your contractor. Failure to clear these errors in a timely fashion, as determined by your contractor, may be grounds for withholding payments.

Edit	Condition
2000	All type 3 records with numeric fields and a positive usage must have values greater than zero (supporting documentation may be required for negative amounts). [09/30/2018]
2005	All elements set forth in Table 3, with subscripts as appropriate, are required in the file. [09/30/2018]
2015	Standard cost center lines, descriptions, and codes should not be changed. (See Table 5.) This edit applies to the standard line only and not subscripts of that code. [09/30/2018]
2020	All standard cost center codes must be entered on the designated standard cost center line and subscripts thereof as indicated in Table 5. [09/30/2018]
2025	Only nonstandard cost center codes within a cost center category may be placed on lines 10, 32, 48, 68, and 81, and subscripts. [09/30/2018]

NOTE: CMS reserves the right to require additional edits to correct deficiencies that become evident after processing the data commences and, as needed, to meet user requirements.

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 04/30/2021

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 filed cost report 2. [ ] Manually submitted cost report 3. [ ] If this is an amended report enter the number of times the provider resubmitted this cost report. 4. [ ] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization .	Date:	Time:
Contractor use only	5. [ ] Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received:_____ 7. Contractor No.:_____ 8. [ ] Initial Report for this Provider CCN 9. [ ] Final Report for this Provider CCN	10. NPR Date:_____ 11. Contractors Vendor Code: _____ 12. [ ] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)}for the cost reporting period beginning _____ and ending _____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☐ I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed) _____
Chief Financial Officer or Administrator of Provider(s)

_____
Title

_____
Date

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:	HRSA Award Number:			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 Poviders					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

	Days	Hours of Operation From 1	To 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
24	Identify days and hours by listing the time the facility operates as other than a RHC next to the applicable day.			24

	Days	Hours of Operation From 1	To 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

FORM CMS-222-17 (05-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-2, SECTION 4604.1)

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

PART I - 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

		Hours of Operation		
		From	To	
	Days	1	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

		Hours of Operation		
		From	To	
	Days	1	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 revenus 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 Vaccines & Med Supplies								31
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 PNEUMOCOCCAL AND INFLUENZA VACCINE COST	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B-1

		PNEUMOCOCCAL 1	INFLUENZA 2	
1	Health care staff cost (from Worksheet A, column 7, line 14)			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 multiplied by line 2)			3
4	Vaccines and related medical supplies cost (from Worksheet A, column 7, lines 30 and 31, respectively)			4
5	Direct cost of pneumococcal and influenza vaccine (sum of lines 3 and 4)			5
6	Total direct cost of the facility (from Worksheet A, column 7, line 39)			6
7	Total facility overhead (from Worksheet A, column 7, line 74)			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 multiplied by line 8)			9
10	Total pneumococcal and influenza vaccine cost and administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from provider records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Medicare cost of pneumococcal and influenza vaccine and administration (line 12 multiplied by line 13)			14
15	Total cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, line 10) Transfer to Worksheet C, Part I, line 2			15
16	Total Medicare cost of pneumococcal and influenza vaccine and administration (sum of columns 1 and 2, 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 pneumococcal and influenza vaccine and administration (from Worksheet B-1, line 15)		2
3	Total allowable cost excluding pneumococcal and influenza vaccine (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	
8	Maximum rate per visit (see instructions)			8
9	Rate for Medicare covered visits (lessor of line 7 or line 8)			9

	PART II - DETERMINATION OF TOTAL PAYMENT	Payment Limit Period 1	Payment Limit Period 2	
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: beneficiary deductible (see instructions)			15
16	Net Medicare cost excluding pneumococcal and influenza vaccine 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 pneumococcal and influenza vaccine 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.

FORM CMS-222-17 (05-2018) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB 15-2, SECTION 4613 THROUGH 4613.2)

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	Contractor approving official signature: Date:					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.