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

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 5 **Date: MARCH 2000**

HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
Table of Contents-Chapter 29	29-1 (1 p.)	29-1 (1 p.)
2990- Exhibit 1	29-301 (2 pp.)	----------
2990 – 2990 (cont.)	29-303-29 - 313 (12 pp.)	----------

NEW/REVISED MATERIAL--EFFECTIVE DATE: for cost reporting periods ending on or after December 31,1996.

Section 2990, Cost Report Forms Exhibit 1- CMS-222-92, this transmittal adds the cost reporting forms to the manual.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

CHAPTER 29

INDEPENDENT RURAL HEALTH CLINIC AND FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER COST REPORT FORM CMS-222-92

EXHIBIT 1- Form CMS-222-92

The following is a listing of the Form CMS –222-92 worksheets and the page number location.

Worksheets	Page(s)
Wkst. S, Part I	29-303
Wkst. S, Parts I (Cont.) & II	29-304
Wkst. A, Page 1	29-305
Wkst. A, Page 2	29-306
Wkst. A-1	29-307
Wkst. A-2	29-308
Wkst. B, Parts I & II	29-309
Wkst. C, Part I	29-310
Wkst. C, Part II	29-311
Supp. Wkst. A-2-1, Parts I-III	29-312
Supp. Wkst. B-1	29-313

FORM APPROVED
OMB NO: 0938-0107

INDEPENDENT RURAL HEALTH CLINIC/FREESTANDING FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	WORKSHEET S - PART I For Intermediary Use Date Received
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).	Intermediary Number

PART I - STATISTICAL DATA [ ] Projected Cost Report [ ] Actual/Final Cost Report

1. Facility Name and Address		1a. County
2. Facility Number	3. Designation	4. Reporting Period From To

5. Type of Control (Check One)

A. Voluntary Non Profit	B. Proprietary		C. Government	
[ ] Corporation	[ ] Individual	[ ] Partnership	[ ] Federal	[ ] County
[ ] Other (Specify)	[ ] Corporation	[ ] Other (Specify)	[ ] State [ ] City	[ ] Other (Specify)

6. Source of Federal Funds	GRANT AWARD NUMBER	DATE
A. Community Health Center (Section 330(d), Public Health Service Act)		
B. Migrant Health Center (Section 329 (d), PHS Act)		
C. Health Services for the Homeless (Section 340(d), PHS Act)		
D. Appalachian Regional Commission		
E . Look-Alikes		
F. Other (Specify)		

7. Names of Physicians Furnishing Services At The Health Facility or Under Agreement (As Described In Instructions) And Medicare Billing Numbers (Include All Part B Billing Numbers)

Name	Billing Number

8. Supervisory Physicians

Name	Hours of Supervision For Reporting Period

FORM CMS-222-92 (10/96) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTIONS 2903 and 2903.1)

INDEPENDENT RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER WORKSHEET STATISTICAL DATA AND CERTIFICATION STATEMENT	WORKSHEET S PART I (Cont.) & PART II

PART I (CONTINUED)-STATISTICAL DATA

9. If the facility operates as other than an RHC or FQHC (i.e., as a physicians office, independent laboratory, etc.) check yes and specify what type of operation and what days and hours RHC/FQHC services and other than RHC or FQHC services are provided at the facility as instructed below.

YES [ ] NO [ ]

Type of Operation _____

Identify days and hours by listing the time the facility operates as an RHC or FQHC next to the applicable da

Sunday _____ Thursday _____
Monday _____ Friday _____
Tuesday _____ Saturday _____
Wednesday _____

Identify days and hours by listing the time the facility operates as other than an RHC or FQHC next to the applicable day(s)

Sunday _____ Thursday _____
Monday _____ Friday _____
Tuesday _____ Saturday _____
Wednesday _____

PART II - CERTIFICATION BY OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying cost report prepared by _____(Provider Name and Number) for the cost report period beginning_____ and ending_____ and that to the best of my knowle and belief, it is a true, correct and complete statement prepared from the books and records of the Provider in accordance with the laws and regulations regarding the Provider in accordance with the laws and regulations regarding the provision of health care services and that the services identified in this cost report v provided in compliance with such laws and regulations.

(Signed)

Officer or Administrator of Facility Title Date

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No.	Reporting Period From To	WORKSHEET A Page 1

	COST CENTER	Compen-sation	Other	Total (Col. 1 + 2)	Reclassi-fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician								1
2	Physician Assistant								2
3	Nurse Practitioner								3
4	Visiting Nurse								4
5	Other Nurse								5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other (Specify)								9
10									10
11									11
12	Subtotal-Facility Health Care Staff Costs								12
	COSTS UNDER AGREEMENT								
13	Physician Services Under Agreement								13
14	Physician Supervision Under Agreement								14
15									15
16	Subtotal Under Agreement (Lines 13-15)								16
	OTHER HEALTH CARE COSTS								
17	Medical Supplies								17
18	Transportation (Health Care Staff)								18
19	Depreciation-Medical Equipment								19
20	Professional Liability Insurance								20
21	Other (Specify)								21
22									22
23									23
24	Subtotal-Other Health Care Costs (Lines 17-23)								24
25	Total Cost of Services (Other Than Overhead And Other RHC/FQHC Services) Sum of Lines 12, 16, And 24								25
	FACILITY OVERHEAD-FACILITY COST								
26	Rent								26
27	Insurance								27
28	Interest On Mortgage Or Loans								28
29	Utilities								29

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2904)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES	Facility No.	Reporting Period From To	WORKSHEET A Page 2

	COST CENTER	Compen-sation	Other	Total (Col. 1 + 2)	Reclassi-fications	Reclassified Trial Balance (Col. 3 +/- 4)	Adjustments Increases (Decreases)	Net Expenses (Col. 5 +/- 6)	
		1	2	3	4	5	6	7	
30	Depreciation-Buildings And Fixtures								30
31	Depreciation-Equipment								31
32	Housekeeping And Maintenance								32
33	Property Tax								33
34	Other(Specify)								34
35									35
36									36
37	Subtotal-Facility Costs (Lines 26-36)								37
	FACILITY OVERHEAD-ADMINISTRATIVE COSTS								
38	Office Salaries								38
39	Depreciation-Office Equipment								39
40	Office Supplies								40
41	Legal								41
42	Accounting								42
43	Insurance (Specify)								43
44	Telephone								44
45	Fringe Benefits And Payroll Taxes								45
46	Other (Specify)								46
47									47
48									48
49	Subtotal-Administrative Cost (Lines 38-48)								49
50	Total Overhead (Lines 37 And 49)								50
	COST OTHER THAN RHC/FQHC SERVICES								
51	Pharmacy								51
52	Dental								52
53	Optometry								53
54	Other (Specify)								54
55									55
56									56
57	Subtotal-Cost Other Than RHC/FQHC (Lines 51-56)								57
	NON-REIMBURSABLE COSTS (Specify)								
58									58
59									59
60									60
61	Subtotal Non-Reimbursable Costs (Lines 58-60)								61
62	TOTAL COSTS (Sum Of Lines 25, 50, 57, And 61)								62

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2904)

RECLASSIFICATIONS	Facility No.	Reporting Period From To	WORKSHEET A-1

	EXPLANATION OF ENTRY	CODE (1)	INCREASE COST CENTER	INCREASE LINE NO.	INCREASE AMOUNT (2)	DECREASE COST CENTER	DECREASE LINE NO.	DECREASE AMOUNT (2)	
		1	2	3	4	5	6	7	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34									34
35									35
36	TOTAL RECLASSIFICATIONS (Sum of Column 4 must equal sum of Column 7)								36

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

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

FORM CMS-222-92 (3/93) (INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II, SECTION 2905)

ADJUSTMENTS TO EXPENSES	Facility No.		Reporting Period From To	WORKSHEET A-2
Description (1)	Basis for Adjust-ment (2)	Amount	Expense Classification on Worksheet A from which amount is to be deducted or to which the amount is to be added: Cost Center	Line No.
	1	2	3	4
1 Investment income on commingled restricted and unrestricted funds (chapter 2)				
2 Trade, quantity and time discounts on purchases (chapter 8)	B			
3 Rebates and refunds of expenses (chapter 8)	B			
4 Rental of building or office space to others				
5 Home office costs (chapter 21)				
6 Adjustment resulting from transactions with related organizations (chapter 10)	From Supp. Wkst. A-2-1			
7 Vending machines				
8 Practitioner Assigned by National Health Service Corps				
9 Depreciation - Buildings and Fixtures			Depreciation	30
10 Depreciation - Equipment			Depreciation	31
11 Other (Specify)				
12 Total				62

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

(2) Basis for adjustment (SEE INSTRUCTIONS)

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

B. Amount Received - if cost cannot be determined.

VISITS AND OVERHEAD COST FOR RHC/FQHC SERVICES	Facility No.		Reporting Period From To		WORKSHEET B PARTS I & II
PART I - VISITS AND PRODUCTIVITY	Part A - Visits And Productivity				
	1	2	3	4	5
Positions	Number of FTE Personnel	Total Visits	Productivity Standard	Minimum Visits (Col. 1 x Col. 3	Greater of Col. 2 or Col. 4
1. Physicians			4200		
2. Physician Assistants			2100		
3. Nurse Practitioners			2100		
4. Subtotal (Sum of lines 1-3)					
5. Visiting Nurse					
6. Clinical Psychologist					
7. Clinical Social Worker					
8. Total Staff					
9. Physician Services Under Agreement					

PART II - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES	
	Amount
10. Cost of RHC/FQHC Services - excluding overhead - (W/S A,Col. 7, Line 25)	
11. Cost of Other Than RHC/FQHC Services - Excluding overhead (W/S A, Col. 7, Sum of Lines 57 and 61	
12. Cost of All Services - excluding overhead - (Sum of Lines 10 and 11)	
13. Ratio of RHC/FQHC Services (Line 10 Divided by Line 12)	
14. Total Overhead - (W/S A, Col. 7, Line 50)	
15. Overhead Applicable to RHC/FQHC Services (Line 13 x Line 14)	
16. Total Allowable Cost of RHC/FQHC Services (Sum of Lines 10 and 15)	

FORM CMS-222-92 (8/94) INSTRUCTIONS FOR THIS WORKSHEET ARE PUBLISHED IN CMS PUB. 15-II SECTIONS 2907 THRU 2907.2)

DETERMINATION OF MEDICARE REIMBURSEMENT	Facility No.	Reporting Period From To	WORKSHEET C PART 1

PART I- DETERMINATION OF RATE FOR RHC/FQHC SERVICES				AMOUNT	
1	Total Allowable Costs(Worksheet B, Part II, Line 16)				1
2	Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supplemental Worksheet B-1, Line 15)				2
3	Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (Line 1 - Line 2)				3
4	Greater of Minimum Visits or Actual Visits by Health Care Staff (Worksheet B, Part 1, Column 5, Line 8				4
5	Physicians Visits Under Agreements (Worksheet B, Part 1, Column 5, Line 9)				5
6	Total Adjusted Visits (Line 4 + Line 5)				6
7	Adjusted Cost Per Visit (Line 3 divided by Line 6)				7
		1	2	3	
8	Maximum Rate Per Visit (See Instructions)				8
9	Rate For Medicare Covered Visits (Lessor of Line 7 or Line 8)				9

DETERMINATION OF MEDICARE PAYMENT		Facility No.	Reporting Period From To	WORKSHEET C PART II	
PART II - DETERMINATION OF TOTAL PAYMENT		1	2	3	
10	Rate for Medicare Covered Visits (Part I, Line 9)				10
11	Medicare Covered Visits Excluding Mental Health Services(From Intermediary Records)				11
12	Medicare Cost Excluding Costs for Mental Health Services(Line 10 multiplied by Line 11)				12
13	Medicare Covered Visits for Mental Health Services(From Intermediary Records)				13
14	Medicare Covered Cost for Mental Health Services(Line 10 multiplied by Line 13)				14
15	Limit Adjustment (Line14 multiplied by 62 1/2%) (see instructions)				15
16	Total Medicare Cost (Line 12 plus line 15)				16
17	Less: Beneficiary Deductible (From Intermediary Records)				17
18	Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its (Their) Administration (Line 16 minus line 17)				18
19	Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine(80% multiplied by line 18, Column 3)				19
20	Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (From Supp. Worksheet B-1, Line)				20
21	Total Reimbursable Medicare Cost (Line 19 plus Line 20)				21
22	Less Payments to RHC/FQHC During Reporting Period				22
23	Balance Due To/From The Medicare Program Exclusive of Bad Debts (Line 21 less Line 22)				23
24	Total Reimbursable Bad Debts, Net of Bad Debt Recoveries (From Provider Records)				24
25	Total Amount Due To/From The Medicare Program (Line 23 plus Line 24)				25

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS	Facility No.	Reporting Period From To	SUPPLEMENTAL WORKSHEET A-2-1 PARTS I-III

Part I. Are there any costs included on Worksheet A which resulted from transactions with related organizations as defined in the Provider Reimbursement Manual, Part I, Chapter 10?

[ ] Yes [ ] No (If "Yes", complete Parts II and III)

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

	LOCATION AND AMOUNT INCLUDED ON WORKSHEET A, COLUMN 6				AMOUNT ALLOWABLE IN COST	NET ADJUSTMENT (COL.4 MINUS COL. 5)	
	Line No.	Cost Center	Expense Items	AMOUNT			
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4
5	TOTALS (sum of lines 1-4) Transfer col. 6, line 1-4 to Wkst. A,col.6 as appropriate) (Transfer col.6, line 5 to Wkst. A-2, col.2, line 6, Adjustment to Expenses)						5

Part II Interrelationship of facility to related organization (s):

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

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

	SYMBOL (1)	Name	Percentage of Ownership	RELATED ORGANIZATION (S) Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
1							1
2							2
3							3
4							4

(1) Use the following symbols to indicate interrelationship to related organizations:

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

CALCULATION AND TOTAL OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Facility No.	Reporting Period From To	SUPPLEMENTAL WORKSHEET B-1

	PART 1 - CALCULATION OF COST	PNEUMOCOCCAL	INFLUENZA	
1	Health Care Staff Cost (Worksheet A, Column 7, Line12)			1
2	Ratio of Pneomococcal and Influenza Vaccine Staff Time to Total Health Care Staff Time			2
3	Pneumococcal and Influenza Vaccine Health Care Staff Cost (Line 1 x Line 2)			3
4	Medical Supplies Cost - Pneumococcal and Influenza Vaccine (From Your Records)			4
5	Direct Cost of Pneumococcal and Influenza Vaccine (Sum of Lines 3 & 4)			5
6	Total Direct Cost of the Facility (Worksheet A, Column , Line 50)			6
7	Total Facility Overhead (Worksheet A, Column 7, Line 50)			7
8	Ratio of Pneumococcal and Influenza Vaccine Direct Cost to Total Direct Cost (Line 5 divided by Line 6)			8
9	Overhead Cost - Pneumococcal and Influenza Vaccine (Line 7 x Line 8)			9
10	Total Pneumococcal and Influenza Vaccine Cost and Its (Their) Administration (Sum of Lines 5 & 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 Its (Their) Administration (Line 12 Multiplied by Line 13)			14
15	Total Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 10, Columns 1 and 2) Transfer to Wkst. C, Part I, Line 2			15
16	Total Medicare Cost of Pneumococcal and Influenza Vaccine and Its (Their) Administration (Sum of Line 14, Columns 1 and 2) Transfer to Wkst. C, Part II, Line 20			16