Medicare

Provider Reimbursement Manual

Part 2, Provider Cost Reporting Forms and Instructions, Chapter 44, Form CMS-224-14

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

Transmittal 1 **Date: April 22, 2016**

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

This transmittal introduces Chapter 44, Federally Qualified Health Center (FQHC) Cost Report, Form CMS-224-14, which implements the Patient Protection and Affordable Care Act (ACA), section 10501(i)(3)(A), establishing a prospective payment system (PPS) for cost reporting periods beginning on or after October 1, 2014. These new instructions and forms must be filed by freestanding FQHCs and FQHCs previously reported as part of a Skilled Nursing Facility (SNF) complex or Home Health Agency (HHA) complex. FQHCs that are part of a hospital healthcare complex must use the Form CMS-2552-10.

Paper Reduction Statement

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 0938-1298. The time required to complete this information collection is estimated at 58 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 FQHC identification data.
3. Worksheet S-1, Part II, collects data for each FQHC 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 S-3, Parts II and III, collects contract labor and employee benefit costs, the number of hours in a normal workweek and the number of FTEs.
7. Worksheet A separately identifies general service and direct patient care costs.
8. Worksheet B, Parts I and II, uses general service costs to calculate the cost per medical and mental health visit by practitioner, and to compute an overall cost per medical and mental health visit for Medicare. Part II calculates the allowable graduate medical education (GME) costs.
9. Worksheet B-1 computes pneumococcal and influenza vaccine costs.
10. Worksheet E-1 captures interim payments made to the FQHC by Medicare.
11. Worksheet F-1 collects income statement information.

CHAPTER 44
FEDERALLY QUALIFIED HEALTH CENTER COST REPORT
CMS-224-14
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4400. GENERAL

The Paperwork Reduction Act of 1995 requires that the private sector be informed as to why information is collected and what the information is used for by the government. In accordance with §§1815(a) and 1861(v)(1)(A) of the Social Security Act (the Act), providers of medical and other health services as defined under §1861(s), participating in the Medicare program are required to submit annual information to achieve settlement of costs for health care services rendered to Medicare beneficiaries. Federally qualified health centers (FQHCs) are required under 42 CFR 405.2470, to maintain adequate financial and statistical records and provide annual cost reports as the Secretary determines necessary to administer the program. The data submitted on the cost reports supports management of Federal programs. The information reported on Form CMS-224-14, must conform to the requirements and principles set forth in the Provider Reimbursement Manual, (CMS Pub. 15), as well as those set forth in the Medicare Benefit Policy Manual, CMS Pub. 100-02, chapter 13, and the Medicare Claims Processing Manual, CMS Pub. 100-04, chapter 9.

Section 10501(i)(3)(A) of the Affordable Care Act (Pub. L. 111-148 and Pub. L. 111-152) added §1834(o) of the Act to establish a new system of payment for the costs of FQHC services under Medicare Part B based on prospectively set rates. The statute requires implementation of the FQHC prospective payment system (FQHC PPS) for FQHCs with cost reporting periods beginning on or after October 1, 2014. Form CMS-224-14 must be used by all freestanding FQHCs for cost reporting periods beginning on or after October 1, 2014. The FQHC cost report must be submitted to the Medicare administrative contractor (hereafter referred to as contractor) electronically in accordance with 42 CFR 413.24(f)(4). Cost reports are due on or before the last day of the fifth month following the close of the period covered by the report. For cost reports ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost reporting period, in accordance with 42 CFR 413.24(f)(2).

NOTE: This form is to be used by freestanding FQHCs and FQHC's previously reported as part of a SNF complex or HHA complex. FQHCs that are part of a hospital healthcare complex must use the Form CMS-2552.

The public reporting and recordkeeping burden for this cost report is estimated to average 58 hours per response. This includes time for reviewing instructions, gathering data, maintaining records, and completing the forms. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to:

Centers for Medicare and Medicaid Services
PRA Reports Clearance Officer
7500 Security Boulevard
Mail Stop C4-26-05
Baltimore, Md. 21244-1850

4400.1 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 per pneumococcal and influenza vaccine injection

2. Round to 6 decimal places:
   a. Ratios
   b. Unit cost multiplier

If a residual exists as a result of computing costs using a fraction, adjust the residual in the largest amount resulting from the computation. For example, in cost finding, a unit cost multiplier is applied to the statistics in determining costs. After rounding each computation, the sum of the allocation may be more or less than the total cost allocated. This residual is adjusted to the largest amount resulting from the allocation so that the sum of the allocated amounts equals the amount allocated.

4401. 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.

A&G	-	Administrative and General
CAP REL	-	Capital-Related
CBSA	-	Core Based Statistical Area
CCN	-	CMS Certification Number (formerly known as provider number)
CFR	-	Code of Federal Regulations
CMS	-	Centers for Medicare & Medicaid Services
ECR	-	Electronic Cost Report
FQHC	-	Federally Qualified Health Center
HCRIS	-	Healthcare Cost Report Information System
HRSA	-	Health Resources and Services Administration
I&R	-	Interns and Residents
MAC	-	Medicare Administrative Contractor
NPR	-	Notice of Program Reimbursement
PCRE	-	Primary Care Residency Expansion
PS&R Report	-	Provider Statistical and Reimbursement Report
RCE	-	Reasonable Compensation Equivalency Limit
THC	-	Teaching Health Center

4402. RECOMMENDED SEQUENCE FOR COMPLETING FORM CMS-224-14

Step No.	Worksheet	Instructions
1	S, Parts I & II	Read §§4404.1 and 4404.2. Complete Parts I and II.
2	S-1, Part I	Read §4405.1. Complete entire worksheet.
3	S-1, Part II	Read §4405.2. Complete entire worksheet.
4	S-2	Read §4406. Complete entire worksheet if applicable.
5	S-3, Part I	Read §4407.1. Complete entire worksheet.
6	S-3, Part II	Read §4407.2. Complete entire worksheet.
7	S-3, Part III	Read §4407.3. Complete entire worksheet.
8	A	Read §4408. Complete columns 1 through 3.
9	A-1	Read §4409. Complete entire worksheet if applicable.
10	A	Read §4408. Complete columns 4 and 5.
11	A-2-1, Parts I & II	Read §4411.1 and 4411.2. Complete entire worksheet if applicable.
12	A-2	Read §4410. Complete entire worksheet.
13	A	Read §4408. Complete columns 6 and 7.
14	B, Parts I & II	Read §§4412.1 and 4412.2. Complete entire worksheet.
15	B-1	Read §4413. Complete entire worksheet.
16	E	Read §4414. Complete lines 1 - 17.
17	E-1	Read §4415. Complete entire worksheet.
18	E	Read §4414. Complete lines 18 - 21 as applicable.
19	F-1	Read §4416. Complete entire worksheet.
20	S, Part III	Read §4404.3. Complete Part III.

4403. SEQUENCE OF ASSEMBLY

The following list of assembly of worksheets is provided so all FQHCs are consistent in the order of submission of their annual cost report. All FQHCs using Form CMS-214-14 are to adhere to this sequence. Where worksheets are not completed because they are not applicable, blank worksheets are not included in the assembly of the cost report.

Worksheet	Part
S	I, II & III
S-1	I & II
S-2	
S-3	I, II & III
A	
A-1	
A-2	
A-2-1	I & II
B	I & II
B-1	
E	
E-1	
F-1	

4404. WORKSHEET S - FEDERALLY QUALIFIED HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

4404.1 Part I - Cost Report Status.--This section is to be completed by the FQHC and contractor as indicated on the worksheet. If this is a consolidated cost report, the organization must choose a primary FQHC 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 FQHCs filing low utilization cost reports in accordance with CMS Pub. 15-2, chapter §110 or FQHCs demonstrating financial hardship in accordance with CMS Pub. 15-2, chapter1, §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 full cost report, an "L" if this is a low Medicare utilization cost report, or an "N" if this is a no Medicare utilization cost report ("L" and "N" require 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 FQHC.

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 FQHC CCN. A final cost report is a terminating cost report for a particular FQHC 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 process this 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.

4404.2 Part II - Certification.--This certification is read, prepared, and signed by an officer or administrator of the FQHC after the cost report has been completed in its entirety

4404.3 Part III - Settlement Summary.--Enter the balance due to or due from the Medicare program. Transfer the amount from Worksheet E, line 20.

4405. WORKSHEET S-1 - FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

This worksheet consists of two parts:

Part I - Federally Qualified Health Center Identification Data
Part II - Federally Qualified Health Center Consolidated Cost Report Participant Identification Data

4405.1 Part I - Federally Qualified Health Center Identification Data.--The information required on this worksheet is needed to properly identify the FQHC, or in the case of a consolidated cost report, the primary FQHC. In the case of a consolidated cost report, only the primary FQHC completes the entire Worksheet S-1, Part I. All other FQHCs filing under a consolidated cost report must be listed on line 14 and its subscripts 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 FQHC operates by entering a number from the list below:

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	

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

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2 for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

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 FQHC is owned, leased or controlled by an entity that operates multiple FQHCs. 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 FQHC, the street address, post office box (if applicable), Health Resources Services Administration (HRSA) grant award number assigned to the organization, city, state, and ZIP code.

Lines 9.--Indicate if this FQHC is 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, post office box (if applicable), the home office CCN, city, state, and ZIP code.

Line 13.--Indicate whether this FQHC is filing a consolidated cost report under CMS Pub. 100-04, chapter 9, §30.8. Enter "Y" for yes or "N" for no, in column 1. If yes, enter in column 2 the date the FQHC requested approval to file a consolidated cost report, in column 3 the date the contractor approved the FQHCs request to file a consolidated cost report, and in column 4 the number of FQHCs included in this consolidated cost report other than the primary FQHC.

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

Line 15.--There are 3 types of organizations that are eligible to enroll in Medicare as FQHCs. Indicate in column 1, the type of organization this FQHC is by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha character (s) associated with the response in column 2. For example if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D." An organization receiving a grant under §330 of the Public Health Service (PHS) Act or an outpatient health program/facility can operate as any or all of the subcategories listed under the respective numeric options presented below.

1) An organization receiving a grant(s) under §330 of the PHS Act:
    A) Community Health Centers
    B) Migrant and Seasonal Agricultural Workers Health Centers
    C) Health Care for the Homeless Health Centers
    D) Health Centers for Residents of Public Housing
2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or

3) Outpatient health program/facility operated by:
   A) A tribe or tribal organization under the Indian Self-Determination Act
   B) An urban Indian organization under title V of the Indian Health Care Improvement Act
   C) Other

Line 16.--Indicate if your FQHC received a grant under §330 of the PHS Act during this cost reporting period. If this is a consolidated cost report, did the primary FQHC reported on line 1, column 2 receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no.

Line 17.--If the response to line 16 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)
4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)
5 = Other

Line 18.--Indicate if your FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the Federal Tort Claims Act (FTCA). Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 19.--Indicate if your FQHC is legally required to carry malpractice coverage. Enter "Y for yes or "No" for no. Malpractice insurance premiums are money paid by the FQHC to a commercial insurer to protect the FQHC against potential negligence claims made by their patients/clients.

Line 20.--If line 19 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 21.--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 FQHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the FQHC where the FQHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often FQHCs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage the FQHC needs but could not obtain economically through the mainstream insurance market.

Line 22.--Indicate if malpractice premiums paid, paid losses, or self-insurance are reported in a cost center other than the Administrative and General (A&G) cost center. Enter "Y" for yes or "N" for no. If yes, submit a supporting schedule listing cost centers and amounts.

Line 23.--Is this FQHC 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 24.--Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.

Line 25.--Indicate if the FQHC received a Primary Care Residency Expansion (PCRE) grant from HRSA to train new residents in primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of primary care full time equivalent (FTE) residents your FQHC trained using PCRE grant funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

Line 26.--Indicate if the FQHC received a Teaching Health Center (THC) development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter the number of FTE residents your FQHC trained using THC funding in column 2, and the total number of visits performed by such residents in column 3, during this cost reporting period.

Line 27.--Indicate if you own or lease the building or office space occupied by your FQHC. Enter a "1" for owned or a "2" for leased in column 1. If you lease the office space, enter the rent/lease expense for this cost reporting period in column 2.

4405.2 Part II - Federally Qualified Health Center Consolidated Cost Report Participant Identification Data.--Each FQHC 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 FQHCs are reported on Worksheet S-1, Part I, line 14 and its subscripts. Do not complete this worksheet for the primary FQHC reported on Worksheet S-1, Part I, line 1.

Line 1.--Enter the FQHC site name in column 1 and the FQHC certification date in column 2. Indicate the type of control under which the FQHC 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 FQHC 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 FQHC 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 FQHC's street address in column 1 and the post office box in column 2 (if applicable).

Line 3.--Enter the city in column 1, state in column 2, ZIP code in column 3, county in column 4, and the appropriate designation ("U" for urban or "R" for rural) in column 5. See CMS Pub. 100-04, chapter 9, §20.6.2 for information regarding urban and rural designations. If you are uncertain of your designation, contact your contractor.

Line 4.--There are 3 types of organizations that are eligible to enroll in Medicare as an FQHC. Indicate in column 1, the type of FQHC organization by entering a number from the list below. If your response in column 1 is "1" or "3", enter any or all of the alpha characters associated with the response in column 2. For example if you entered "1" in column 1, enter in column 2, "A", "B", "C" and/or "D". An organization receiving a grant under §330 of the PHS Act or an outpatient health program/facility can operate as any or all of the subcategories listed under the respective numeric options below.

1) An organization receiving a grant(s) under §330 of the PHS Act:
    A) Community Health Centers
    B) Migrant and Seasonal Agricultural Workers Health Centers
    C) Health Care for the Homeless Health Centers
    D) Health Centers for Residents of Public Housing
2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of "Health Center" under §330 of the PHS Act, but not receiving grant funding under §330; or
3) Outpatient health program/facility operated by:
    A) A tribe or tribal organization under the Indian Self-Determination Act
    B) An urban Indian organization under title V of the Indian Health Care Improvement Act
    C) Other

Line 5.--Indicate if your FQHC received a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no.

Line 6.--If the response to line 5 is yes, indicate in column 1, the type of grant that was awarded from the list below. Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.

1 = Community Health Center (§330(e), PHS Act)
2 = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
3 = Health Care for the Homeless Health Centers (§330(h), PHS Act)
4 = Health Centers for Residents of Public Housing (§330(i), PHS Act)
5 = Other

Line 7.--Indicate if your FQHC submitted an initial deeming or annual redeeming application for medical malpractice coverage to HRSA under the FTCA. Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.

Line 8.--Indicate if your FQHC is legally required to carry malpractice coverage. Enter "Y for yes or "N" for no. Malpractice insurance premiums are money paid by the FQHC to a commercial insurer to protect the FQHC against potential negligence claims made by their patients/clients.

Line 9.--If line 8 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 10.--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 FQHC to compensate a patient/client for professional negligence. Malpractice self-insurance is money paid by the FQHC where the FQHC acts as its own insurance company (either as a sole or part-owner) to financially protect itself against professional negligence. Often FQHCs will manage their own funds or purchase a policy referred to as captive insurance, which provides insurance coverage the FQHC needs but could not obtain economically through the mainstream insurance market.

Line 11.--Is this FQHC 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.

Line 12.--Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.

Line 13.--Indicate if the FQHC received PCRE grant funding from HRSA to train new residents in primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of primary care FTE residents your FQHC trained using PCRE grant funding, and enter in column 3 the total number of visits performed by such residents during this cost reporting period.

Line 14.--Indicate if the FQHC received a THC development grant authorized under Part C of title VII of the PHS Act from HRSA for the purpose of establishing new accredited or expanded primary care residency programs. Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents your FQHC trained using THC funding and enter in column 3 the total number of visits performed by such residents during this cost reporting period.

Line 15.--Indicate whether you own or lease the building or office space occupied by your FQHC. Enter a "1" for owned or a "2" for leased in column 1. If you lease the office space, enter the rent/lease expense for this cost reporting period in column 2.

4406. WORKSHEET S-2 - FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT QUESTIONNAIRE

This worksheet collects organizational, financial and statistical information previously reported on Form CMS-339. Where instructions for this worksheet direct the FQHC 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 FQHC.

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 FQHCs reported on Worksheet S-1, Part I, line 1.

Line 1.--Indicate whether the FQHC 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 FQHC 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 FQHC 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 FQHC 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 no, 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 47. 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 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, Health Insurance Claim (HIC) 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, HIC 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 beneficiary.

Columns 7 & 8--Date First Bill Sent to Beneficiary & Date Collection Efforts Ceased.--This information should be obtained from the FQHC's files and should correlate with the beneficiary name, HIC 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, HIC 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.--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.--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 FQHC'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 FQHC's 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 FQHC 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 detail 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 FQHC). If the FQHC 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

FQHC Name _____ Prepared By _____
FQHC CCN _____ Date Prepared _____
FYE _____

Patient Name	HIC. 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 FQHC 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.

4407. WORKSHEET S-3 - FEDERALLY QUALIFIED HEALTH CENTER DATA

This worksheet consists of three parts:

Part I - Federally Qualified Health Center Statistical Data
Part II - Federally Qualified Health Center Contract Labor and Benefit Cost
Part III - Federally Qualified Health Center Employee Data

4407.1 Part I - Federally Qualified Health Center Statistical Data.--This part 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 FQHC can be seen for three types of visits:

- Medical Visit - A face to face encounter between an FQHC patient and one of the following: a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse, registered dietician, or certified DSMT/MNT educator.
- Medical Visit for Subsequent Illness or Injury
- Mental Health Visit - A face to face encounter between an FQHC patient and one the of the following: a clinical psychologist, clinical social worker, or a physician, physician assistant, nurse practitioner, certified nurse midwife, visiting registered nurse, visiting licensed practical nurse for mental health services.

All visits performed by interns and residents who are funded by a THC or PCRE grant from HRSA must be excluded from lines 5 and 6 on this worksheet. Visits performed by an intern or resident funded by a THC or PCRE grant from HRSA are separately reported on the Worksheet S-1, Parts I and II.

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

Columns 1 through 4.--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) and all other payors. Include dually eligible (Medicare/Medicaid) beneficiaries in column 2.

Column 5.--Enter the sum of the total medical visits, mental health visits and visits performed by interns and residents included in columns 1 through 4.

Line 1.--Enter the number of medical visits applicable to columns 1 through 4. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the FQHC 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 FQHC 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 4, for each FQHC 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 4. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the FQHC 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 FQHC 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 4, for each FQHC 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 not funded by a THC or PCRE grant from HRSA applicable to columns 1 through 4. 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 FQHC 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 4 for each FQHC listed on line 5 and its subscripts.

Line 6.--Enter the total number of visits performed by interns and residents not funded by a THC or PCRE grant from HRSA (sum of line 5 and its subscripts) for each applicable column.

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

4407.2 Part II - Federally Qualified Health Center Contract Labor and Benefit Cost.--This section identifies the contract labor and benefit costs relating to direct patient care. See Worksheet A for the applicable cost center definitions.

DEFINITIONS

Column 1 - Contract Labor Costs.--Enter the amount paid for services furnished under contract, rather than by employees, for direct patient care and management services for the occupations on lines 2 through 15. Line 1 is the aggregate of lines 2 through 15. DO NOT include cost for equipment, supplies, travel expenses, and other miscellaneous or overhead items (non-labor costs).

Column 2 - Benefit Costs.--Enter the amount of employee benefit costs, also referred to as wage-related costs, for direct patient care services for the occupations listed on lines 2 through 15. Line 1 is the aggregate of lines 2 through 15.

4407.3 Part III - Federally Qualified Health Center Employee Data.--This section identifies data related to the human resources of the FQHC. The human resources statistics are required for each of the job categories specified in lines 16 through 29.

Enter the number of hours in your normal work week.

Report in column 1 the FTE employees on the FQHC's payroll. These are staff for which an IRS Form W-2 is used.

Report in column 2 the FTE contracted and consultant staff of the FQHC.

Complete staff FTEs for column 1 as follows: Add all hours for which employees were paid and divide by 2080. Round to two decimal places, e.g., 04447 is rounded to .04. Compute contract FTE's for column 2 as follows: Add all hours for which contracted and consultant staff worked and divide by 2080 hours. If employees are paid for unused vacation, unused sick leave, etc., exclude these paid hours from the numerator in the calculations.

Enter the total FTEs in column 3, by adding columns 1 and 2.

4408. WORKSHEET A - RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts. The cost centers listed may not apply to every FQHC using these forms. For example, a FQHC that does not have an intern and resident program will not complete lines 47 and/or 78. Complete only those lines that are applicable.

If the cost elements of a cost center are maintained separately on your accounting 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 (subscript) 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. The added line is identified as a numeric subscript of the immediately preceding line. For example, if two lines are added between lines 7 and 8, identify them as lines 7.01 and 7.02.

Cost center coding is a methodology for standardizing the meaning of cost center labels as used by health care entities on the Medicare cost reports. Form CMS-224-14 provides for preprinted cost center descriptions 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. These cost center descriptions are hereafter referred to as the standard cost centers. Additionally, nonstandard cost center descriptions have been identified through analysis of frequently used labels.

This coding methodology allows FQHCs 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 FQHC's label in the ECR file provide standardized meaning for data analysis. FQHCs are required to compare any added or changed labels 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 §4495, table 5**.**

Submit the working trial balance for 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 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 cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2). The sum of columns 1 and 2 must equal column 3.

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 FQHC's accounting books and records.

Column 2.--Enter all costs other than salaries from the FQHC'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-1. The net total of the entries in column 4 must equal zero on line 100. Show reductions to expenses as negative numbers.

Column 5.--For each cost center, enter the total of the amount in column 3 plus or minus the amount in column 4. The total on column 5, line 100 must equal the total on column 3, line 100.

Column 6.--For each cost center, enter the net of any increase and decrease amounts from Worksheet A-2. The total on Worksheet A, column 6, line 100 must equal Worksheet A-2, column 2, line 50.

Column 7.--For each cost center, enter the total of the amount in column 5 plus or minus the amount in column 6.

LINE DESCRIPTIONS

The Worksheet A segregates the trial balance of expenses into general service cost centers, direct patient care cost centers, reimbursable pass through costs, other FQHC services, and nonreimbursable cost centers to facilitate the transfer of costs to the various worksheets.

GENERAL SERVICE COST CENTERS

These cost centers include expenses incurred in operating the FQHC as a whole that are not directly associated with furnishing patient care such as, but not limited to mortgage, rent, plant operations, administrative salaries, utilities, telephone, and computer hardware and software costs. General service cost centers furnish services to other general service cost centers and to reimbursable and nonreimbursable cost centers in the FQHC.

Lines 1 and 2 - Cap Rel Costs-Bldg & Fix and Cap Rel Costs-Mvble Equip.--These cost centers include the capital-related costs for buildings and fixtures and the capital-related costs for movable equipment including depreciation, leases and rentals for the use of facilities and/or equipment, including electronic health records systems, interest incurred in acquiring land and depreciable assets used for patient care, insurance on depreciable assets used for patient care, taxes on land or depreciable assets used for patient care, and software and hardware updates attributable to electronic health records systems. Do not include in these cost centers costs incurred for the repair or maintenance of equipment or facilities; amounts specifically included in rentals or lease payments for repair and/or maintenance agreements; interest expense incurred to borrow working capital or for any purpose other than the acquisition of land or depreciable assets used for patient care; general liability insurance or any other form of insurance to provide protection other than the replacement of depreciable assets; or taxes other than those assessed on the basis of some valuation of land or depreciable assets used for patient care. However, if no amount of the lease payment is identified in the lease agreement for maintenance, you are not required to carve out a portion of the lease payment to represent the maintenance portion. Thus, the entire lease payment is considered a capital-related cost subject to the provisions of 42 CFR 413.130(b).

Line 3 - Employee Benefits.--This cost center includes the costs of the employee benefits department. In addition, this cost center includes the fringe benefits paid to, or on behalf of, an employee when an FQHC's accounting system is not designed to accumulate the benefits on a departmentalized or cost center basis. (See CMS Pub. 15-1, chapter 21, §2144).

Line 4 - Administrative and General (A&G) Services.--A&G includes a wide variety of administrative costs such as but not limited to cost of fiscal services, legal and accounting services, facility administrative services (not already included in other general services cost centers), etcetera.

Line 5 - Plant Operation and Maintenance.--This cost center includes expenses incurred in the plant operation and maintenance of the FQHC. These costs include the maintenance and service of utility systems such as heat, light, water, air conditioning and air treatment. This cost center also includes costs incurred in maintaining the facility and grounds, such as costs of routine painting, plumbing, mowing, and snow removal.

Line 6 - Janitorial.--This cost center includes the cost of routine janitorial activities such as mopping, vacuuming, cleaning restrooms, lobbies, waiting areas and otherwise maintaining patient and non-patient care areas.

Line 7 - Medical Records.--This cost center includes the cost of the medical records department where patient medical records are maintained. The general library and the medical library are not included in this cost center but are included in the A&G cost center. None of the costs associated with electronic health records systems are reported in this cost center.

Line 8 - Subtotal - Administrative Overhead.--Enter the total of lines 1 through 7.

Line 9 - 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 FQHC visit. Drugs and pharmacy supplies that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Part B, C, or D of Medicare must be included on line 67 (Drugs Charged to Patients) of this worksheet. Drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services provided by a retail pharmacy are reported on line 77. Do not include the cost of pneumococcal and influenza vaccines on this line as these costs are reported on lines 48 and 49, respectively.

Line 10 - 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. Do not include the cost of medical supplies used in administering influenza and pneumococcal vaccines on this line as these costs are reported on lines 48 and 49, respectively.

Line 11 - Transportation.--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 FQHC business.

Line 12 - Other General Service (Specify).--Use this line to report the costs of other general service costs not previously identified on lines 1 through 11. If more than one other general service is offered, subscript this line. See Table 5 in §4495 for the proper cost center code for this line.

Line 13 - Subtotal - Total Overhead.--Enter the sum of lines 8 and 9 through 12.

Line 14 through 22.--Reserved for future use.

DIRECT CARE COST CENTERS

Line 23 - Physician.--This cost center includes the costs incurred by the FQHC 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. Reclassify the cost for the portion of time physicians spent on general supervisory services or other FQHC administrative activities to A&G (line 4). The costs incurred for teaching physicians and interns and residents must be reported on line 47 or line 48, whichever is applicable.

Line 24 - Physician Services Under Agreement.--This cost center includes the costs incurred by the FQHC for physicians who are providing services under agreement.

Line 25 - Physician Assistant.--This cost center includes the costs incurred by the FQHC for physician assistants (PA), including the costs for PAs providing physician services.

Line 26 - Nurse Practitioner.--This cost center includes the costs of nursing care provided by nurse practitioners (NP), including NPs providing physician services.

Line 27 - Visiting Registered Nurse.--This cost center only includes the costs of nursing care provided by registered nurses (RNs) who perform visiting nurse services in accordance with CMS Pub. 100-02, chapter 13, §180. Costs associated with RNs who provide services incident to a physician, PA, NP, certified nurse midwife (CNM), clinical psychologist (CP) or clinical social worker (CSW) (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140) are included in line 36.

Line 28 - Visiting 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, §180. Costs associated with LPNs that provide services incident to a physician, PA, NP, CNM, CP or CSW (see CMS Pub. 100-02, chapter 13, §§110, 120 and 140) are included in line 36.

Line 29 - Certified Nurse Midwife.--This cost center includes the costs of nursing care provided by CNMs.

Line 30 - Clinical Psychologist.--This cost center includes the costs of a 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 31 - Clinical Social Worker.--This cost center includes the costs of a 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 32 - 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 33 - Reg Dietician/Cert DSMT/MNT Educator.--This cost center includes the costs of a person who is either a registered dietician or nutritionist who meets specified criteria for providing diabetes self-management training (DSMT) or medical nutrition therapy (MNT) services under the Program.

Line 34 - Physical Therapist.--This cost center includes the costs of physical or corrective treatment of bodily or mental conditions by the use of physical, chemical, and other properties of heat, light, water, electricity, sound massage, and therapeutic exercise by or under the direction of a registered physical therapist as prescribed by a physician. Physical therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 35 - Occupational Therapist.--This cost center includes the costs of purposeful goal-oriented activities in the evaluation, diagnosis, and/or treatment of persons whose function is impaired by physical illness or injury, emotional disorder, congenital or developmental disability, or the aging process, in order to achieve optimum functioning, to prevent disability, and to maintain health. Occupational therapy services may be provided for purposes of symptom control or to enable the individual to maintain activities of daily living and basic functional skills.

Line 36 - Other Allied Health Personnel.--This cost center includes the costs of RNs and LPNs who provide services incident to a physician, PA, NP, CNM, CP or CSW in accordance with CMS Pub. 100-02, chapter 13, §§110, 120 or 140 and the costs of other allied health personnel that provide diagnostic, technical, therapeutic and direct patient care and support services to the other health professionals they work with and the patients they serve. An example of other allied health personnel is a medical assistant.

Line 37 - Subtotal Direct Patient Care Services.--Enter the total of lines 23 through 36.

Line 38 through 46.--Reserved for future use.

REIMBURSABLE PASS THROUGH COSTS

Line 47 - Allowable GME 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, excluding all overhead included in the general service cost centers paid under the FQHC PPS.

An FQHC 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 47, 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 47, the FQHC 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 FQHC. Therefore, costs associated with a "moonlighting" intern or resident are reported in the physician services cost center, not the allowable GME cost center.

Line 48 - Pneumococcal Vaccines & Med Supplies.--This cost center includes the cost of the pneumococcal vaccines and the medical supplies attributable to pneumococcal vaccinations.

Line 49 - Influenza Vaccines & Med Supplies.--This cost center includes the cost of the influenza vaccines and the medical supplies attributable to influenza vaccinations.

Line 50 - Subtotal - Reimbursable Pass Through Costs.--Enter the total of lines 47 through 49.

Line 51 through 59.--Reserved for future use.

OTHER FQHC SERVICES

Line 60 - Medicare Excluded Services.--This cost center includes the cost of routine dental care, hearing tests, eye exams, etc. that are excluded from coverage under the Program.

Line 61 - Diagnostic & Screening Lab Tests.--This cost center includes the technical component of diagnostic and laboratory tests such as electrocardiograms and certain preventative services authorized by the Medicare statute or the national coverage determination process. (The professional component is a FQHC service if performed by an FQHC practitioner or furnished incident to an FQHC service). This does not include venipuncture, which is included in the pharmacy cost center when furnished by the FQHC.

Line 62 - Radiology - Diagnostic.--This cost center includes the technical component of radiological diagnostic tests such as x-rays and imaging services.

Line 63 - Prosthetic Devices.--This cost center includes the costs of devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), replacement of such devices, and one pair of conventional eyeglasses or contact lenses furnished subsequent to each cataract surgery with the insertion of an intraocular lens.

Line 64 - Durable Medical Equipment.--This cost center includes the direct costs of durable medical equipment rented or sold (DME, as defined in 42 CFR 410.38) furnished to an individual patient and all direct expenses incurred in requisitioning and issuing DME to patients.

Line 65 - Ambulance Services.--Report all ambulance costs on this line for both owned and operated services and services under arrangement. No subscripting is allowed for this line.

Line 66 - Telehealth.--This cost center includes the cost of telehealth distant-site services as described in CMS Pub. 100-02, chapter 13, §190.

Line 67 - Drugs Charged to Patients.--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that can be traced to individual patients that are paid separately (outside the FQHC PPS national encounter rate) under Medicare Parts B, C, or D.

Line 68 - Chronic Care Management (CCM).--This cost center includes the structured recording of patient health information, an electronic health care plan addressing all health issues, access to chronic care management 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 Federal Register, vol. 80, November 16, 2015, page 71080.

Line 69 - Other (Specify).--Use this line to report the costs of other FQHC services not previously identified on lines 60 through 68. If more than one other service is offered, subscript this line. See Table 5 in §4495 for the proper cost center code for this line.

Line 70 - Subtotal Other FQHC Services.--Enter the total of lines 60 through 69.

NONREIMBURSABLE COST CENTERS

Line 71 through 76.--Reserved for future use.

Line 77 - Retail Pharmacy.--This cost center includes only those costs associated with drugs (both prescription and over the counter), pharmacy supplies, pharmacy personnel and pharmacy services that are sold through a retail pharmacy.

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

Line 79 - Other Nonreimbursable (Specify).--Use this line to record the costs applicable to other nonreimbursable cost centers not provided for on this worksheet.

Line 80 - Subtotal of Nonreimbursable Cost Centers.--Enter the total of lines 77 through 79.

Line 81 through 99.--Reserved for future use.

Line 100 - Total.--Enter the sum of lines 13, 37, 50, 70 and 80.

4409. WORKSHEET A-1 - 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.

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.

4410. WORKSHEET A-2 - 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, §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.

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-2-1, 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.

4411. WORKSHEET A-2-1 - 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 FQHC by organizations related to the FQHC 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 FQHC by organizations related to the FQHC or costs associated with the 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.

4411.1 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 FQHC 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.

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 home office.

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

4411.2 Part II - Interrelationship to Related Organizations and/or Home Office.-- This part of the worksheet identifies the interrelationship between the FQHC and individuals, partnerships, corporations, or other organizations having either a related interest to, a common ownership with, or control over the FQHC 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 FQHC and the related organization or home office. Select from the following choices:

Symbol	Relationship
A	Individual has financial interest (stockholder, partner, etc.) in both related organization and in 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 FQHC, enter the percent of ownership.

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

Column 5.--If the FQHC, 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).

4412. WORKSHEET B - CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS

Worksheet B consists of two parts. Part I is used to summarize (1) the FQHC medical and mental health visits furnished by practitioners, including health care staff and physicians under agreement, and (2) apportion overhead costs to FQHC services to determine the cost per visit for a medical visit and a mental health visit, by practitioner. The cost per visit calculated in Part I is not used to determine payment under the FQHC PPS, but may be used in future payment analyses. Part II is used to determine the FQHC's Medicare reimbursable direct GME costs, where applicable.

4412.1 Part I - Calculation of Federally Qualified Health Center Cost Per Visit.--The purpose of Part I is to establish the FQHC medical and mental health Medicare cost per visit.

Column 1.--Enter the total cost for each practitioner from Worksheet A, column 7 as indicated on the worksheet.

Column 2.--Enter the total medical and mental health visits actually furnished to all patients by each practitioner during the cost reporting period. Each visit to the FQHC by the beneficiary counts as a single visit, even in the case where a beneficiary returns to the FQHC in the same day for a subsequent illness or injury. A beneficiary can have up to three medical visits in a day to include the initial visit and two subsequent visits for illness or injury.

NOTE: Column 2, line 11 must equal Worksheet S-3, Part I, column 5, sum of lines 2 and 4. For each line 1 through 10, column 2 must equal the sum of columns 7 and 8.

Column 3.--Use this column to allocate costs associated with other direct care costs, sum of Worksheet A, column 7, lines 9, 32, and 34 through 36. Calculate the unit cost multiplier (UCM) related to other direct care costs by dividing the sum of Worksheet A, column 7, lines 9, 32, 34, 35, and 36, by Worksheet B, Part I, column 2, line 11, total medical and mental health visits, and enter the result on line 12. Calculate the costs for lines 1 through 10 by multiplying the visits on each corresponding line, column 2, times the UCM on line 12.

Column 4.--Use this column to allocate general service costs, on Worksheet A, column 7, line 13, minus line 9. Calculate the UCM by dividing Worksheet A, column 7, line 13, minus line 9, by Worksheet A, column 7, line 100, minus line 13, plus line 9, and enter the result on line 12. Allocate the general service cost attributable to each practitioner on lines 1 through 10, by multiplying the UCM times the sum of the amounts in columns 1 and 3, for each corresponding line.

Column 5.--Enter the sum of columns 1, 3, and 4 for each practitioner.

Column 6.--Calculate the average cost per visit by each practitioner by dividing the total cost in column 5 by the total visits in column 2. Enter the result in column 6.

Column 7.--Enter the total number of medical visits, included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 8.--Enter the total number of mental health visits, included in column 2, provided to all patients by each practitioner during the cost reporting period.

Column 9.--Enter the total number of medical visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

Column 10.--Enter the total number of mental health visits provided to Medicare beneficiaries by each practitioner during the cost reporting period.

NOTE: Worksheet S-3, Part I, column 2, line 2, must equal column 9, line 11; and Worksheet S-3, Part I, column 2, line 4, must equal column 10, line 11.

Column 11.--Calculate the Medicare cost per medical visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 9.

Column 12.--Calculate the Medicare cost per mental health visit by practitioner by multiplying the average cost per visit in column 6 by the Medicare visits in column 10.

Line 11.--Enter the sum of lines 1 through 10 for the applicable columns.

Line 13, column 6.--Calculate the FQHC average cost per visit by dividing column 5, line 11 by column 2, line 11.

Line 13, column 11.--Calculate the Medicare average cost per medical visit by dividing column 11, line 11 by column 9, line 11.

Line 13, column 12.--Calculate the Medicare average cost per mental health visit by dividing column 12, line 11 by column 10, line 11.

4412.2 Part II - Calculation of Allowable Direct Graduate Medical Education Costs.--The purpose of Part II is to calculate the allowable cost of direct GME costs that will be reimbursed by the Medicare program.

Column 1.--Enter the total amount of direct GME cost from Worksheet A, column 7, line 47.

Column 2.--Enter the total number of visits performed by interns and residents from Worksheet S-3, Part I, line 6, column 5.

Column 3.--Enter the total number of title XVIII visits performed by interns and residents from Worksheet S-3, Part I, line 6, column 2.

Column 4.--Divide column 3, by column 2. Enter the result in column 4 and round to six decimal places.

Column 5.--Multiply the amount in column 1 by the result in column 4. Enter the result in column 5. This is the amount that Medicare will reimburse the FQHC for its direct GME activities.

4413. WORKSHEET B-1 - COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

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

Line 1.--Enter the health care staff cost from Worksheet A, column 7, sum of lines 23, and 25 through 36, in columns 1 and 2, as applicable. Physician services under agreement are excluded from this total.

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 services 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 48 and 49, in columns 1 and 2, respectively.

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

Line 6.--Enter the total direct costs of the FQHC from Worksheet A, column 7, line 100, minus Worksheet A, column 7, line 8.

Line 7.--Enter the administrative overhead of the FQHC from Worksheet A, column 7, line 8.

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 ratio 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.--Compute the FQHC cost per pneumococcal and influenza vaccine injection by dividing the costs on line 10 by the number of injections 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 Medicare cost per pneumococcal and influenza vaccine injection by multiplying the cost per vaccine on line 12 by the number of injections administered to Medicare beneficiaries on line 13.

Line 15.--Enter the total cost of pneumococcal and influenza vaccines and their administration by entering the sum of the amounts in columns 1 and 2, line 10.

Line 16.--Enter the Medicare cost of pneumococcal and influenza vaccines and their administration by entering the sum of the amount in columns 1 and 2, line 14. Transfer this amount to the Worksheet E, line 3.

4414. WORKSHEET E - CALCULATION OF REIMBURSEMENT SETTLEMENT

This worksheet provides for the reimbursement calculation of FQHC services rendered to program patients under the FQHC PPS. It also provides for an accumulation of cost reimbursable direct graduate medical education payments, pneumococcal and influenza vaccine reimbursement, and Medicare Advantage (MA) supplemental payments.

Line 1.--FQHC services are paid in accordance with FQHC PPS. Enter the total PPS payments paid for FQHC visits rendered during the cost reporting period. Obtain this amount from the provider statistical and reimbursement (PS&R) report.

Line 2.--Enter the Medicare costs for direct graduate medical education from Worksheet B, Part II, line 14, column 5.

Line 3.--Enter the Medicare costs for pneumococcal and influenza vaccines and their administration from Worksheet B-1, line 16.

Line 4.--Medicare advantage supplemental payments are made to an FQHC when the amount paid by the managed care organization is less than the amount paid under the FQHC PPS on a per visit basis. Enter the total amount of Medicare advantage supplemental payments from the PS&R, report type 778. This data is captured for information purposes only and does not impact cost report settlement.

Line 5.--Enter the sum of lines 1 through 3.

Line 6.--Enter the primary payer amounts from the PS&R.

Line 7.--Enter the result of line 5 minus line 6.

Line 8--Enter the Part B coinsurance.

Line 9--Enter the result of line 7 minus line 8.

Line 10.--Enter Medicare allowable bad debts, reduced by bad debt recoveries. If recoveries exceed the current year's bad debts, lines 10 and 11 will be negative.

Line 11.--Multiply the amount (including negative amounts) from line 10 by 65 percent.

Line 12--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 10.

Line 13.--Enter the sum of lines 9 and 11.

Line 14.--Enter any other adjustments. Provide a description in the space provided.

Line 15.--Enter the result of line 13 plus or minus line 14.

Line 16.--Enter the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 15]. Do not apply the sequestration calculation when gross reimbursement is less than zero.

Line 17.--Enter the result of line 15 minus line 16.

Line 18.--Enter the amount of interim payments from Worksheet E-1, column 2, line 4.

Line 19.--FOR CONTRACTOR USE ONLY.--Enter the tentative settlement amount from Worksheet E-1, column 2, line 5.99.

Line 20.--Enter the total amount due to/from the program (line 17 minus lines 18 and 19). Transfer this amount to Worksheet S, Part III, column 1, line 1.

Line 21.--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 CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the supporting details and computations for this line.

4415. WORKSHEET E-1 - ANALYSIS OF PAYMENTS TO THE FEDERALLY QUALIFIED HEALTH CENTER 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 FQHC. 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 E, line 18.

DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-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 FQHC 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 FQHC 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 E, line 20.

NOTE: On lines 3, 5, and 6, when an FQHC to program amount is due, show the amount and date on which the FQHC 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 E, line 17.

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

4416. WORKSHEET F-1 - STATEMENT OF REVENUE AND EXPENSES

This worksheet is prepared from your accounting books and records. It requires the reporting of total patient revenues (specifically including Medicare, Medicaid and other revenues) for the entire FQHC and operating expenses for the entire FQHC. Additional worksheets may be submitted if necessary.

Line 1.--Enter total patient revenue from your accounting books and/or records in columns 1 through 3, by program as indicated. Enter the sum of columns 1 through 3 in column 4.

Line 2.--Enter total patient revenues not received in column 2. This includes:

Provision for Bad Debts,
Contractual Adjustments,
Charity Discounts,
Teaching Allowances,
Policy Discounts,
Administrative Adjustments, and
Other Deductions from Revenue

Line 3.--Enter in column 2, the sum of line 1, column 4 minus line 2, column 2.

Line 4.--Enter in column 2, total operating expenses from Worksheet A, column 3, line 100.

Lines 5 through 9.--Enter any additions to operating expenses in column 1.

Line 10.--Enter in column 2, the sum of lines 5 through 9, column 1.

Lines 11 through 15.--Enter any subtractions to operating expenses in column 1.

Line 16.--Enter in column 2, the sum of lines 11 through 15, column 1.

Line 17.--Enter in column 2, the sum of line 4, column 2, plus line 10, column 2, minus line 16, column 2.

Line 18.--Enter in column 2, the sum of line 3, column 2, minus line 17, column 2.

Lines 19 through 31.--Enter all other income as specified in column 1.

Line 32.--Enter in column 2, the sum of the amounts on lines 19 through 31, column 1.

Line 33.--Enter in column 2, the sum of line 18, column 2, plus line 32, column 2.

This page is reserved for future use.

Form CMS-224-14 Worksheets

The following is a listing of the Form CMS-224-14 worksheets and the page number location. Changes to worksheets are indicated by redline on this and the subsequent page for this transmittal. Where only the page number changes, no redlining is indicated.

This page is reserved for future use.

EXHIBIT 2-ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE OF CONTENTS

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 1 - RECORD SPECIFICATIONS

Table 1 specifies the standard record format required for the four types of records in an electronic cost reporting (ECR) file. Type 1 records contain information for identifying the provider, for processing the cost report, and for vendor validation. Type 2 records contain the line and column labels. Type 3 records contain data necessary to calculate the Federally Qualified Health Center (FQHC) cost report. Table 3 provides specifications for the layout of type 3 records. Type 4 records contain the ECR file encryption coding, records 1, 1.01, and 1.02.

The medium for electronically submitting the cost report to a contractor is CD, flash drive, or contractor-approved form such as electronic mail, or secured website. The file must be in IBM format and the character set must be ASCII. Providers must seek approval from their contractor regarding the method of submission to ensure that the method of transmission is acceptable. An ECR file sent electronically must be a compressed or self-extracting file.

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
1234567890123456789012345678901234567890123456789012345678901234567890
1           1   213975201427420152739A99P00120153202014274
1           4       14:30
```

Record #1: This is a cost report file submitted by CCN 213975 for the period from October 1, 2014 (2014274) through September 30, 2015 (2015273). It is filed on Form CMS-224-14. It is prepared with vendor number A99's PC based system, version number 1. Position 38 changes with each new test case and/or re-approval and is an alpha character. Positions 39 and 40 remain constant for approvals issued after the first test case. This file is prepared by the FQHC on November 16, 2015 (2015320). The electronic cost report specifications, dated October 1, 2014 (2014274), were used to prepare this file.

FILE NAMING CONVENTION

Name each cost report ECR file in the following manner:
FQNNNNNN.YYLC, where
1. FQ (FQHC 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 FQHCs 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 FQHCs 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-224-14
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.	For Future Use	10	9	2-11	Alpha numeric
3.	Space	1	X	12	
4.	Record Number	1	X	13	Constant "1"
5.	Spaces	3	X	14-16	
6.	FQHC CCN 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 "9" (for Form CMS-224-14)
10.	Vendor Code	3	X	38-40	To be supplied upon approval. Refer to page 44-202.
11.	Vendor Equipment	1	X	41	P = PC; M = Main Frame
12.	Version Number	3	X	42-44	Version of extract software, e.g., 001=1st, 002=2nd, etc. or 101=1st, 102=2nd. The version number must be incremented by 1 with each recompile and release to client(s).
13.	Creation Date	7	9	45-51	YYYYDDD - Julian date; date on which the file was created (extracted from the cost report)
14.	ECR Spec. Date	7	9	52-58	YYYYDDD - Julian date; date of electronic cost report specifications used in producing each file. Valid for cost reporting periods beginning on or after 2014274 (10/1/2014).

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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	#2 - Reserved for future use.
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 cost report is created. This is represented in military time as alpha numeric. Use positions 21 through 25. Example: 2:30PM is expressed as 14:30. #5 to #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.	Worksheet 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.

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.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 1 - RECORD SPECIFICATIONS

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

Line	Description
1	CAP REL COSTS-BLDG & FIX
2	CAP REL COSTS-MVBLE EQUIP
3	EMPLOYEE BENEFITS
4	ADMINISTRATIVE & GENERAL SERVICES
5	PLANT OPERATION & MAINTENANCE
6	JANITORIAL
7	MEDICAL RECORDS
9	PHARMACY
10	MEDICAL SUPPLIES
11	TRANSPORTATION
23	PHYSICIAN
24	PHYSICIAN SERVICES UNDER AGREEMENT
25	PHYSICIAN ASSISTANT
26	NURSE PRACTITIONER
27	VISITING REGISTERED NURSE
28	VISITING LICENSED PRACTICAL NURSE
29	CERTIFIED NURSE MIDWIFE
30	CLINICAL PSYCHOLOGIST
31	CLINICAL SOCIAL WORKER
32	LABORATORY TECHNICIAN
33	REG DIETICIAN/CERT DSMT/MNT EDUCATOR
34	PHYSICAL THERAPIST
35	OCCUPATIONAL THERAPIST
36	OTHER ALLIED HEALTH PERSONNEL
47	ALLOWABLE GME COSTS
48	PNEUMOCOCCAL VACCINES & MED SUPPLIES
49	INFLUENZA VACCINES & MED SUPPLIES
60	MEDICARE EXCLUDED SERVICES
61	DIAGNOSTIC & SCREENING LAB TESTS
62	RADIOLOGY - DIAGNOSTIC
63	PROSTHETIC DEVICES
64	DURABLE MEDICAL EQUIPMENT
65	AMBULANCE SERVICES
66	TELEHEALTH
67	DRUGS CHARGED TO PATIENTS
68	CHRONIC CARE MANAGEMENT
77	RETAIL PHARMACY
78	NONALLOWABLE GME COSTS

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 1 - RECORD SPECIFICATIONS

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

Examples:

Worksheet A line labels with embedded cost center codes:

```
* 2A000000    1       0100CAP REL COSTS-BLDG & FIX
* 2A00000000002000000000200CAP REL COSTS-MVBLE EQUIP
  2A000000    4       0400ADMINISTRATIVE & GENERAL
  2A000000    10      1000MEDICAL SUPPLIES
  2A000000    11      1100TRANSPORTATION
  2A000000    26      2600NURSE PRACTITIONER
  2A000000    63      6300PROSTHETIC DEVICES
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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.	Worksheet 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.
	Spaces	4	X	57-60	Spaces (optional).
	b) Numeric Data	16	9	21-36	Right justified. May contain embedded decimal point. Leading zeroes are suppressed; trailing zeroes 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
12345678901234567890123456789012345678901234567890123456789012345678901234567890
3A000000    4    1             120502
3A000000   11    1              46347
3A000000   28    2                469
3A000000   62    2               8547
```

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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 sub line numbers as data must be uniform.

Worksheet A-1, columns 3 and 6
Worksheet A-2, column 4
Worksheet A-2-1, Part I, column 1

Examples of records (*) with a Worksheet A line number as data and a number line for reference are listed below. Example of grand total record for Worksheet A-1(**).

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789

   3A1000C0    3    0  RADIOLOGY EXPENSE
   3A1000C0    3    1  C
 * 3A1000C0    3    3             62.00
   3A1000C0    3    4             41857
 * 3A1000C0    3    6             32.00
   3A1000C0    3    7             41857
   3A1000C0  100    4             41857
   3A1000C0  100    7             41857
** 3A100000  100    4             60000
** 3A100000  100    7             60000
```

RECORD NAME: TYPE "3" RECORDS

```
          1         2         3         4         5         6
12345678901234567890123456789012345678901234567890123456789

   3A200000   9    1   B
   3A200000   9    2               -125
 * 3A200000   9    4               4.00


 * 3A210001    1    1              6.00
   3A210001    1    3  CLEANING SERVICES
   3A210001    1    4              7500
   3A210001    1    5              6000
```

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 time in which the ECR file is created and saved to an electronic medium to ensure the integrity of the file.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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 characters of the worksheet indicator (positions 2 and 3 of the record identifier) always show the worksheet. The third character of the worksheet indicator (position 4 of the record identifier) is used as part of the worksheet, e.g., A-2-1. The fourth character of the worksheet indicator (position 5 of the record identifier) is not used. Except for Worksheet A-1 (to handle the reclassification code), the fifth and sixth characters of the worksheet indicator (positions 6 and 7 of the record identifier) identify worksheets required by a Federal program (18 = title XVIII, 05 = title V, or 19 = title XIX) or worksheets required for the facility (00 = Universal). The seventh character of the worksheet indicator (position 8 of the record identifier) represents the worksheet part.

Worksheets That Apply to the Federally Qualified Health Center Cost Report

Worksheet	Worksheet Indicator
S, Part I	S000001
S, Part III	S000003
S-1, Part I	S100001
S-1, Part II	S100012 (c)
S-2	S200000
S-3, Part I	S300001
S-3, Parts II and III	S300002 (a)
A	A000000
A-1	A100?A0 (b)
A-2	A200000
A-2-1, Parts I and II	A210000 (a)
B, Parts I and II	B000000 (a)
B-1	B100000
E	E000000
E-1	E100000
F-1	F100000

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 2 - WORKSHEET INDICATORS

FOOTNOTES:

(a) Worksheets With Multiple Parts Using Identical Worksheet Indicator
While this worksheet has several parts, the lines are numbered sequentially. This 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 S-3, Part II & III; A-2-1; and B.

(b) Worksheet A-1
For Worksheet A-1, include in the worksheet identifier the reclassification code as the 5th and 6th digits (6th and 7th of the record). For example, 3A1000A0 or 3A1000B0, 3A1000C0, 3A100AA0, 3A100AB0, or 3A100ZZ0. Additionally, for Worksheet A-1 include in the worksheet identifier "00" in the 5th and 6th digits (6th and 7th of the record) (3A100000) to identify grand total reclassification increases and grand total reclassification decreases.

(c) Worksheets S-1, Part II for Consolidated Cost Reports
For Worksheet S-1, Part II, the fifth and sixth digits of the worksheet indicator (positions 6 and 7 of the record) are numeric from 01-99 to accommodate cost reports with one or more consolidated FQHCs. The number for each additional page of the worksheet is incremented by 1.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

INTRODUCTION

This table identifies those data elements necessary to calculate an FQHC cost report. It also identifies some figures from a completed cost report. These calculated fields (e.g., Worksheet B, Part I, column5) are needed to verify the mathematical accuracy of the raw data elements and to isolate differences between the file submitted by the FQHC and the report produced by the contractor. Where an adjustment is made, that record must be present in the electronic data file. For explanations of the adjustment(s) 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 15. It is unacceptable to format in a series of 10, 20, or to skip sub line 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. 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 provider skips or deletes a line number 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-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S				
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	9
Medicare Utilization - Enter "F" for full, "L" for low, or "N" for no.	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	9
Part III: Settlement Summary				
Balances due provider or program:				
title XVIII	1	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-1, PART I				
Part I: Federally Qualified Health Center Identification Data				
Site Name	1	1	36	X
Provider CCN (xxxxxx)	1	2	6	X
CBSA number (xxxxx)	1	3	5	X
Date Certified (mm/dd/yyyy)	1	4	10	X
Type of control (see Table 3B)	1	5	2	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
Designation (R for Rural or U for Urban)	3	5	1	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 FQHC part of an entity that owns, leases or controls multiple FQHCs? (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 FQHC 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? (Y/N) If yes, enter the chain organization's information below.	9	1	1	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-224-14
TABLE 3 – LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-1, PART I (Cont.)				
Consolidated Cost Report				
Is this FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? (Y/N) (see instructions) If yes, complete line 14, beginning with line 14.01. If no, leave line 14 blank.	13	1	1	X
Date Requested (mm/dd/yyyy)	13	2	10	X
Date Approved (mm/dd/yyyy)	13	3	10	X
Number of FQHCs	13	4	2	9
Site Name	14.01-14.99	1	36	X
FQHC CCN (xxxxxx)	14.01-14.99	2	6	X
CBSA number (xxxxx)	14.01-14.99	3	5	X
Date Requested (mm/dd/yyyy)	14.01-14.99	4	10	X
Date Approved (mm/dd/yyyy)	14.01-14.99	5	10	X
FQHC Operations				
What type of organization is this FQHC? Enter "1", "2", or "3" (see instructions)	15	1	1	X
If column 1 is "1" or "3", enter any or all of the applicable alpha characters in column 2. (see instructions)	15	2	4	X
Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the FQHC reported on line 1, column 2 receive a grant under §330 of the PHS Act during this cost reporting period? (Y/N)	16	1	1	X
If line 16 is "Y" enter the type of HRSA grant that was awarded in column 1. (see Table 3B) (see instructions)	17	1	1	X
If line 16 is "Y" enter the date of the grant award in column 2. (mm/dd/yyyy)	17	2	10	X
If line 16 is "Y" enter the grant award number in column 3.	17	3	20	X
Medical Malpractice				
Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? (Y/N)	18	1	1	X
If column 1 is "Y" enter the effective date of coverage in column 2. (mm/dd/yyyy)	18	2	10	X
Is this FQHC legally-required to carry malpractice insurance? (Y/N)	19	1	1	X
Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	20	1	1	X
List malpractice premiums in column1, paid losses in column 2 and self-insurance in column 3.	21	1-3	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-1, PART I (Cont.)				
Are malpractice premiums, paid losses, or self-insurance reported in a cost center other than the Administrative and General cost center? (Y/N) If yes, submit supporting schedule listing cost centers and amounts.	22	1	1	X
Interns and Residents				
Is this FQHC involved in training residents in an approved GME program in accordance with 42 CFR 405.2468(f)? (Y/N)	23	1	1	X
Is this FQHC involved in training residents in an unapproved GME program? (Y/N)	24	1	1	X
Did this FQHC receive a Primary Care Residency Expansion (PCRE) grant authorized under Part C of title VII of the PHS Act from HRSA? (Y/N)	25	1	1	X
If yes, enter in column 2 the number of primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding. (see instructions)	25	2	9	9(3).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	25	3	11	9
Did this FQHC receive a Teaching Health Center development grant authorized under Part C of title VII of the PHS Act from HRSA? (Y/N)	26	1	1	X
If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period. (see instructions)	26	2	9	9(3).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	26	3	11	9
Capital Related Costs - Ownership/Lease of Building				
Do you own or lease the building or office space occupied by your FQHC? Enter “1” for owned or “2” for leased in column 1.	27	1	1	X
If you enter “2” in column 1, enter the amount of rent/lease expense in column 2.	27	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-1, PART II				
Part II: Federally Qualified Health Center Consolidated Cost Report Participant Identification Data				
Site Name	1	1	36	X
Date Certified (mm/dd/yyyy)	1	2	10	X
Type of control (see Table 3B)	1	3	2	X
Date Decertified (mm/dd/yyyy)	1	4	10	X
Enter "V" for a voluntary termination or an "I" for an involuntary termination	1	5	1	X
Enter date of the change of ownership (mm/dd/yyyy) (see instructions)	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
Designation ("R" for Rural or "U" for Urban)	3	5	1	X
FQHC Operations				
What type of organization is this FQHC? Enter "1", "2", or "3". (see instructions)	4	1	1	X
If column 1 is "1" or "3", enter any or all of the applicable alpha characters in column 2. (see instructions)	4	2	4	X
Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? (Y/N)	5	1	1	X
If line 5 is "Y" enter the type of HRSA grant that was awarded in column 1. (see Table 3B) (see instructions)	6	1	1	X
If line 5 is "Y" enter the date of the grant award in column 2. (mm/dd/yyyy)	6	2	10	X
If line 5 is "Y" enter the grant award number in column 3.	6	3	20	X
Medical Malpractice				
Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? (Y/N)	7	1	1	X
If column 1 is "Y" enter the effective date of coverage in column 2. (mm/dd/yyyy)	7	2	10	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-1, PART II (Cont.)				
Is this FQHC legally-required to carry malpractice insurance? (Y/N)	8	1	1	X
Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	9	1	1	X
List malpractice premiums in column1, paid losses in column 2 and self-insurance in column 3.	10	1-3	11	9
Interns and Residents				
Is this FQHC involved in training residents in an approved GME program in accordance with 42 CFR 405.2468(f)? (Y/N)	11	1	1	X
Is this FQHC involved in training residents in an unapproved GME program? (Y/N)	12	1	1	X
Did this FQHC receive a Primary Care Residency Expansion (PCRE) grant authorized under Part C of title VII of the PHS Act from HRSA? (Y/N)	13	1	1	X
If yes, enter in column 2 the number of primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding. (see instructions)	13	2	9	9(3).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	13	3	11	9
Did this FQHC receive a Teaching Health Center development grant authorized under Part C of title VII of the PHS Act from HRSA? (Y/N)	14	1	1	X
If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period. (see instructions)	14	2	9	9(3).99
If yes, enter in column 3 the number of visits performed by such residents during this cost reporting period.	14	3	11	9
Capital Related Costs - Ownership/Lease of Building				
Do you own or lease the building or office space occupied by your FQHC? Enter "1" for owned or "2" for leased in column 1.	15	1	1	X
If you enter "2" in column 1, enter the amount of rent/lease expense in column 2.	15	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2				
Provider Organization and Operation				
Has the FQHC changed ownership immediately prior to the beginning of the cost reporting period? (Y/N) (see instructions)	1	1	1	X
If yes, enter the date of the change in column 2. (mm/dd/yyyy)	1	2	10	X
Has the FQHC terminated participation in the Medicare program? (Y/N)	2	1	1	X
If yes, enter in column 2 the termination date. (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 FQHC 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) (see instructions)	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) If yes, see instructions	6	1	1	X
Are GME costs directly assigned to cost centers other than Allowable Intern and Resident Costs on Worksheet A? If yes, see instructions	7	1	1	X
Bad Debts				
Is the FQHC seeking reimbursement for bad debts? (Y/N)	8	1	1	X
If line 8 is yes, did the FQHC'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

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-2 (Cont.)				
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 FQHC'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). If yes, see instructions.	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) If yes, see instructions.	14	1	1	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
If yes, describe the other adjustments.	15	0	36	X
Was the cost report prepared only using the FQHC's records? (Y/N) If yes, see instructions.	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
Telephone Number	19	1	36	X
Email Address	19	2	36	X

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET S-3, PART I				
Part I: Federally Qualified Health Center Statistical Data				
Use this column only when filing a consolidated cost report to identify each FQHC 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, 3, 5	1	11	9
Title XVIII: enter the number of medical visits, mental health visits, and visits performed by interns/residents.	1, 3, 5	2	11	9
Title XIX: enter the number of medical visits, mental health visits, and visits performed by interns/residents.	1, 3, 5	3	11	9
Enter the number of medical visits, mental health visits, and visits performed by interns/residents for all other patients.	1, 3, 5	4	11	9
WORKSHEET S-3, PART II and III				
Part II: Federally Qualified Health Center Contract Labor and Benefit Cost				
Contract Labor Cost:				
Total facility's contract labor	1	1	11	-9
Total facility's benefit cost	1	2	11	-9
Personnel specific contract labor cost	2-15	1	11	-9
Personnel specific benefit cost	2-15	2	11	-9
Part III: Federally Qualified Health Center Employee Data				
Number of hours in a normal work week	16	0	6	99.99
Number of full-time equivalent employees:				
Staff	16-29	1	6	9(3).99
Contract	16-29	2	6	9(3).99
Total	16-29	3	6	9(3).99

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A				
Salaries	3-7, 9-12, 23-36, 47-49, 60-69, 77-79	1	11	-9
Other Costs	1-7, 9-12, 23-36, 47-49, 60-69, 77-79	2	11	-9
Net Expense for Allocation	1-7, 9-12, 23-36, 47-49, 60-69, 77-79	7	11	-9
Total	100	1, 2, 7	11	9
WORKSHEET A-1				
For each expense reclassification:				
Explanation	1-99	0	36	X
Code	1-99	1	2	X
Increases:				
Worksheet A line number	1-99	3	6	99.99
Reclassification amount	1-99	4	11	9
Decreases:				
Worksheet A line number	1-99	6	6	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-2				
Description of adjustment	14-49	0	36	X
Basis (A or B)*	1-6, 8-49	1	1	X
Amount*	1-6, 8-49	2	11	-9
Worksheet A line number +	3-6, 8-10, 14-49	4	6	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-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET A-2-1				
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	6	99.99
Expense item(s)	1-4	3	36	X
Amount allowable in cost	1-4	4	11	-9
Amount included in Worksheet A	1-4	5	11	-9
Net Adjustment(s)	1-4	6	11	-9
Total	5	4-6	11	-9
Part II - Interrelationship to related organizations and/or home office				
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
Percent of ownership in provider	6-10	3	6	9(3).99
Name of related organization	6-10	4	36	X
Percent of ownership of related organization	6-10	5	6	9(3).99
Type of business	6-10	6	36	X
WORKSHEET B				
Part I - Calculation of Federally Qualified Health Center Cost Per Visit				
Total medical and mental health visits by practitioner	1-10	2	11	9
Total medical visits by practitioner	1-10	7	11	9
Total mental health visits by practitioner	1-10	8	11	9
Total XVIII medical visits provided to beneficiaries by practitioner	1-10	9	11	9
Total XVIII mental health visits provided to beneficiaries by practitioner	1-10	10	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET B-1				
Ratio of pneumococcal and vaccine staff time to total health care staff time	2	1 & 2	8	9.9(6)
Total number of pneumococcal and influenza vaccine injections	11	1 & 2	11	9
Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries	13	1 & 2	11	9
WORKSHEET E				
Enter total PPS payments paid for FQHC visits rendered during the cost reporting period	1	1	11	9
Medicare advantage supplemental payments	4	1	11	9
Primary payer payments	6	1	11	9
Coinsurance billed to program beneficiaries	8	1	11	9
Allowable bad debts (see instructions)	10	1	11	-9
Allowable bad debts for dual eligible beneficiaries (see instructions)	12	1	11	-9
Other adjustments (specify) (see instructions)	14	0	36	X
Other adjustments (specify) (see instructions)	14	1	11	-9
Sequestration adjustment (see instructions)	16	1	11	9
Protested amounts	21	1	11	-9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET E-1				
Total interim payments paid to FQHC	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
Date of each tentative settlement payment (mm/dd/yyyy)	5.01-5.98	1	10	X
Amount of each tentative settlement payment:				
Program to Provider	5.01-5.49	2	11	9
Provider to Program	5.50-5.98	2	11	9

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 3 - LIST OF DATA ELEMENTS WITH WORKSHEET, LINE, AND COLUMN DESIGNATIONS

Description	Line(s)	Column(s)	Field Size	Usage
WORKSHEET F-1				
Gross patient revenue	1	1-3	11	9
Less: Allowances and discounts on patients' accounts	2	2	11	9
Additions to operating expenses (specify)	5-9	0	36	X
Additions to operating expenses (specify)	5-9	1	11	9
Subtractions from operating expenses (specify)	11-15	0	36	X
Subtractions from operating expenses (specify)	11-15	1	11	9
Other income:				
Contributions, donations, bequests, etc.	19	1	11	9
Income from investments	20	1	11	9
Purchase discounts	21	1	11	9
Rebates and refunds of expenses	22	1	11	9
Sale of medical and nursing supplies to other than patients	23	1	11	9
Sale of durable medical equipment to other than patients	24	1	11	9
Sale of drugs to other than patients	25	1	11	9
Sale of medical records and abstracts	26	1	11	9
Government appropriations	27	1	11	9
Other revenues (specify)	28-31	0	36	X
Other revenues (specify)	28-31	1	11	9

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ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14

TABLE 3A - WORKSHEETS REQUIRING NO INPUT

Worksheet B, Part II

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

TABLE I: Type of Control

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

TABLE II: Types of organizations that can enroll in a FQHC

1) An organization receiving a grant(s) under §330 of the PHS Act :

A = Community Health Center (§330(e), PHS Act)
B = Migrant and Seasonal Agricultural Workers Health Center (§330(g), PHS Act)
C = Health Care for the Homeless Health Centers (§330(h), PHS Act)
D = Health Centers for Residents of Public Housing (§330(i), PHS Act)

2) Health Center Program Look-Alikes; Organizations that have been identified by HRSA as meeting the definition of Health Center under §330 of the PHS Act, but not receiving grant funding under §330

3) Outpatient health program/facility operated by:

A = A tribe or tribal organization under the Indian Self-Determination Act
B = An urban Indian organization under title V of the Indian Health Care Improvement Act
C = Other

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14

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, 15, 16, and 18-27
Worksheet S-1, Part II: lines 1-5 and 7-15
Worksheet S-2: ALL
Worksheet S-3, Part I: lines 2, 4, and 6
Worksheet S-3, Part II and III: ALL
Worksheet A: lines 1-11, 13, 23-37, 47-50, 60-68, 70, 77, 78, 80, and 100
Worksheet A-1: ALL
Worksheet A-2: lines 1-13, and 50
Worksheet A-2-1 Part I: lines 1-3, and 5
Worksheet A-2-1 Part II: lines 6-9
Worksheet B, Parts I and II: ALL
Worksheet B-1: ALL
Worksheet E: lines 1-13, and 15-21
Worksheet E-1: lines 1, 2, 4, 6, and 7
Worksheet F-1: lines 1-4, 10, 16-27, 32, and 33

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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 exclusive 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 precoded), 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 will 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 44-231. 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.

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 FQHC on the Medicare cost report. The use of this coding methodology allows the FQHC 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 12, 69, and 79. 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.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 5 - COST CENTER CODING

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 12 may only contain cost center codes within the general service cost center category of both standard and nonstandard coding. For example, in the general service cost center category for "Other General Service (specify)" cost, line 12 and subscripts must contain cost center codes of 1200 through 1219 which are identified as nonstandard cost center codes. This logic must hold true for all other cost center categories, i.e., direct care, reimbursable pass through costs, other FQHC services, and nonreimbursable cost centers.

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 5 - COST CENTER CODING

TABLE 5 - STANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Cap Rel Costs-Bldg & Fixt	0100	(01)
Cap Rel Costs-Mvble Equip	0200	(01)
Employee Benefits	0300	(01)
Administrative & General	0400	(01)
Plant Operation & Maintenance	0500	(01)
Janitorial	0600	(01)
Medical Records	0700	(01)
Pharmacy	0900	(01)
Medical Supplies	1000	(01)
Transportation	1100	(01)
DIRECT CARE COST CENTERS		
Physician	2300	(01)
Physician Services Under Agreement	2400	(01)
Physician Assistant	2500	(01)
Nurse Practitioner	2600	(01)
Visiting Registered Nurse	2700	(01)
Visiting Licensed Practical Nurse	2800	(01)
Certified Nurse Midwife	2900	(01)
Clinical Psychologist	3000	(01)
Clinical Social Worker	3100	(01)
Laboratory Technician	3200	(01)
Reg Dietician/Cert DSMT/ MNT Educator	3300	(01)
Physical Therapist	3400	(01)
Occupational Therapist	3500	(01)
Other Allied Health Personnel	3600	(01)
REIMBURSABLE PASS THROUGH COSTS		
Allowable GME Costs	4700	(01)
Pneumococcal Vaccines & Med Supplies	4800	(01)
Influenza Vaccines & Med Supplies	4900	(01)
OTHER FQHC SERVICES		
Medicare Excluded Services	6000	(01)
Diagnostic & Screening Lab Tests	6100	(01)
Radiology-Diagnostic	6200	(01)
Prosthetic Devices	6300	(01)
Durable Medical Equipment	6400	(01)
Ambulance Services	6500	(01)
Telehealth	6600	(01)
Drugs Charged to Patients	6700	(01)
Chronic Care Management	6800	(01)
NONREIMBURSABLE COST CENTERS		
Retail Pharmacy	7700	(01)
Nonallowable GME Costs	7800	(01)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 5 - COST CENTER CODING

TABLE 5 - NONSTANDARD COST CENTER DESCRIPTIONS AND CODES

	CODE	USE
GENERAL SERVICE COST CENTERS		
Other General Service (specify)	1200	(20)
OTHER FQHC SERVICES		
Other (specify)	6900	(20)
NONREIMBURSABLE COST CENTERS		
Other Nonreimbursable (specify)	7900	(20)

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
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 FQHCs must automate all of these edits. Failure to properly implement these edits may result in the suspension of a vendor's system certification until corrective action is taken. The vendor's software should provide meaningful error messages to notify the FQHC of the cause of every exception. The edit message generated by the vendor systems must contain the related 4 digit and 1 alpha character, where indicated, reject/edit code specified below. Any file submitted by a provider containing a Level I edit will be rejected by the contractors. Notification must be made to CMS for any exceptions.

The edits are applied at two levels. Level I 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 FQHCs from generating an electronic cost report (ECR) file when the cost report violates any Level I edits. Level II edits (2000 series edit codes) identify potential inconsistencies and missing data items. These items should be resolved at the FQHC 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 FQHCs from generating an ECR file where Level I edit conditions exist. In addition, ample warnings should be given to the FQHC where Level II edit conditions are violated.

Level I edit conditions are to be applied against title XVIII services only. However, any inconsistencies or omissions that would cause a Level I condition for non-title XVIII services must be resolved prior to acceptance of the cost report. [10/01/2014b]

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 [10/01/2014], 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 [10/01/2014b], 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 [10/01/2014s], indicates the edit is effective for services rendered on or after the date in brackets.

I. Level I Edits (Minimum File Requirements)

Edit	Condition
1000	The first digit of every record must be 1, 2, 3, or 4 (encryption code only). [10/01/2014b]
1005	No record may exceed 60 characters. [10/01/2014b]
1010	All alpha characters must be in upper case, exclusive of the vendor information, type 1 record, record number 3 and the encryption code, type 4 record, record numbers 1, 1.01, and 1.02. [10/01/2014b]
1015	The end of the record indicator must be a carriage return and line feed, in that sequence. [10/01/2014b]
1020	The FQHC provider number (record #1, positions 17-22) must be valid and numeric. [10/01/2014b]
1025	All calendar format dates must be edited for 10 character format, e.g. 10/01/2014 (MM/DD/YYYY). [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit Condition

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 a possible date. [10/01/2014b]

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). [10/01/2014b]

1036 The fiscal year ending date (record #1, positions 30 through 36) must be 28 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). [10/01/2014b]

1040 The vendor code (record #1, positions 38 through 40) must be a valid code. [10/01/2014b]

1045 The type 1 record #1 must be correct and the first record in the file. [10/01/2014b]

1047 The following 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. [10/01/2014b]

Cost Center	Line	Code
Cap Rel Costs-Bldg & Fixt	1	0100
Cap Rel Costs-Mvble Equip	2	0200
Employee Benefits	3	0300
Administrative & General Services	4	0400
Plant Operation & Maintenance	5	0500
Janitorial	6	0600
Medical Records	7	0700
Pharmacy	9	0900
Medical Supplies	10	1000
Transportation	11	1100
Physician	23	2300
Physician Services Under Agreement	24	2400
Physician Assistant	25	2500
Nurse Practitioner	26	2600
Visiting Registered Nurse	27	2700
Visiting Licensed Practical Nurse	28	2800
Certified Nurse Midwife	29	2900
Clinical Psychologist	30	3000
Clinical Social Worker	31	3100
Laboratory Technician	32	3200
Reg Dietician/Cert DSMT/MNT Educator	33	3300
Physical Therapist	34	3400
Occupational Therapy	35	3500
Other Allied Health Personnel	36	3600

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit Condition

1047 (Cont.)

Cost Center	Line	Code
Allowable GME Costs	47	4700
Pneumococcal Vaccines & Med Supplies	48	4800
Influenza Vaccines & Med Supplies	49	4900
Medicare Excluded Services	60	6000
Diagnostic & Screening Lab Tests	61	6100
Radiology-Diagnostic	62	6200
Prosthetic Devices	63	6300
Durable Medical Equipment	64	6400
Ambulance Services	65	6500
Telehealth	66	6600
Drugs Charged to Patients	67	6700
Chronic Care Management	68	6800
Retail Pharmacy	77	7700
Nonallowable GME Costs	78	7800

1050 All record identifiers (positions 1 through 20) must be unique. [10/01/2014b]

1055 Only a Y or N is valid for fields that require a yes/no response. [10/01/2014b]

1060 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. [10/01/2014b]

1070 Cost center integrity must be maintained throughout the cost report. For subscripted lines, the relative position must be consistent throughout the cost report. [10/01/2014b]

1075 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. [10/01/2014b]

1080 Every line used on Worksheet A, must have a corresponding type 2 record. [10/01/2014b]

1085 Fields requiring numeric data (days, costs, etc.) may not contain any alpha characters. [10/01/2014b]

1090 A numeric field (except unit cost multipliers) cannot exceed more than 11 positions. Unit cost multipliers cannot exceed 13 positions. . [10/01/2014b]

1095 In all cases where the file includes both a total and the parts which comprise that total, each total must equal the sum of its parts. [10/01/2014b]

1100 All dates must be possible, e.g., no “00”, no “30” or “31” of February and cannot be greater than the current date, except for Worksheet S-2, column 3, line 4. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit	Condition
1000S	Worksheet S-1, Part I, lines 1 through 3 must contain: the FQHC site name in column 1, line 1; the FQHC street address in column 1, line 2; the FQHC city name in column 1, line 3; the FQHC 2-letter state abbreviation in column 2, line 3; the FQHC ZIP code (formatted as XXXXX) or the FQHC ZIP+4 code (formatted as XXXXX-XXXX) in column 3, line 3; the FQHC county name in column 4, line 3; and, the FQHC CCN in column 2, line 1. [10/01/2014b]
1001S	If Worksheet S, Part I, line 5, is "5" (amended cost report), then line 3 must be greater than zero. [10/01/2014b]
1005S	Worksheet S-1, Part I, column 3, line 1 must be completed with a valid five-position alphanumeric CBSA code. [10/01/2014b]
1010S	The FQHC 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-1000 through XX-1199, or XX-1800 through XX-1989, where XX corresponds to the two digit state code. [10/01/2014b]
1015S	Worksheet S-1, Part I, column 5, line 1 (type of control) must have a value of 1 through 11. (See Table 3B.) [10/01/2014b]
1020S	Worksheet S-1, Part I, column 5, line 3 must contain an "R" or "U" response. [10/01/2014b]
1025S	The cost reporting period beginning date on Worksheet S-1, Part I, column 1, line 4, must be on or after October 1, 2014. [10/01/2014b]
1030S	The cost reporting period beginning date on Worksheet S-1, Part I, column 1, line 4, must precede the cost reporting ending date on Worksheet S-1, Part I, column 2, line 4. [10/01/2014b]
1035S	On Worksheet S-1, Part I, there must be a "Y" or "N" response for: **Column 1:** lines 5, 9, 13, 16, 18, 19, 22, 23, 24, 25, and 26. [10/01/2014b]
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. [10/01/2014b]
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. [10/01/2014b]
1080S	The certification dates for the primary FQHC (Worksheet S-1, Part I, column 4, line 1) and for each consolidated FQHC entered on Worksheet S-1, Part II, column 2, line 1 must be present and possible, and must be on or before the cost reporting period beginning date (Worksheet S-1, Part I, column 1, line 4) and after 01/01/1966. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit	Condition
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 one, for the number of consolidated FQHCs and if Worksheet S-1, Part I, column 4, line 1, is on or after 10/01/2014, column 2 must contain a date of request, and column 3 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". [10/01/2014b]
1110S	If Worksheet S-1, Part I, column 1, line 13 is "Y", then line 14, beginning with subscripted line 14.01, for each FQHC must contain: the FQHC site name in column 1, the FQHC 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 10/01/2014, 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. [10/01/2010b]
1120S	If Worksheet S-1, Part I, column 1, line 15, is "1" or "3", then column 2 must have only an A, B, C, and/or D and vice versa. If Worksheet S-1, Part I, column 1, line 15 is "2", then column 2 must be blank and vice versa. [10/01/2014b]
1140S	If Worksheet S-1, Part I, column 1, line 16, is "Y", then line 17 must contain the type of grant award in column 1 (see Table 3B), the date of the grant award in column 2 (MM/DD/YYYY), and the grant award number in column 3. If Worksheet S-1, Part I, column 1, line 16 is "N", then line 17 must be blank. [10/01/2014b]
1150S	If Worksheet S-1, Part I, column 1, line 18 is "Y", then column 2 must contain a valid date (MM/DD/YYYY) and vice versa. [10/01/2014b]
1170S	If Worksheet S-1, Part I, line 19 is "Y", then line 20 must contain a "1" or "2", and line 21, sum of columns 1 through 3, must be greater than zero, and vice versa. [10/01/2014b]
1210S	If Worksheet S-1, Part I, column 1, line 25 is "Y", then columns 2 and 3 must be greater than zero, and vice versa. [10/01/2014b]
1220S	If Worksheet S-1, Part I, column 1, line 26 is "Y", then columns 2 and 3 must be greater than zero and vice versa. [10/01/2014b]
1230S	Worksheet S-1, Part I, column 1, line 27, must contain a response of "1" or "2". If the response to column 1 is "2", then column 2 must have an amount greater than zero, and vice versa. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

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

Edit	Condition
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 FQHC: the FQHC site name in column 1, line 1; the FQHC street address in column 1, line 2; the FQHC city name in column 1, line 3; the FQHC 2-letter state abbreviation in column 2, line 3; the FQHC ZIP code (formatted as XXXXX) or the FQHC ZIP+4 code (formatted as XXXXX-XXXX) in column 3, line 3; the FQHC county name in column 4, line 3; and an "R" or "U" in column 5 , line 3. [10/01/2014b]
1250S	For each consolidated FQHC 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.) [10/01/2014b]
1280S	Worksheet S-1, Part II, column 5, line 3 must contain an "R" or "U" response. [10/01/2014b]
1290S	If Worksheet S-1, Part II, column 1, line 4, is "1" or "3", then column 2 must have only an A, B, C, and/or D and vice versa. If Worksheet S-1, Part II, column 1, line 4 is "2", then column 2 must be blank and vice versa. [10/01/2014b]
1300S	If Worksheet S-1, Part I, column 1, line 13 is "Y", for each consolidated FQHC 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 5, 7, 8, 11, 12, 13, and 14. [10/01/2014b]
1310S	If Worksheet S-1, Part II, column 1, line 5, is "Y", then line 6 must contain the type of grant award in column 1 (see Table 3B), the date of the grant award in column 2 (MM/DD/YYYY), and the grant award number in column 3. If Worksheet S-1, Part II, column 1, line 5 is "N", then line 6 must be blank. [10/01/2014b]
1320S	If Worksheet S-1, Part II, column 1, line 7 is "Y", then column 2 must contain a valid date (MM/DD/YYYY), and vice versa. [10/01/2014b]
1340S	If Worksheet S-1, Part II, line 8 is "Y", then line 9 must contain a "1" or "2", and line 10, sum of columns 1 through 3, must be greater than zero, and vice versa. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit	Condition
1370S	If Worksheet S-1, Part II, column 1, line 13 is "Y", then both columns 2 and 3 must be greater than zero and vice versa. [10/01/2014b]
1380S	If Worksheet S-1, Part II, column 1, line 14 is "Y", then both columns 2 and 3 must be greater than zero and vice versa. [10/01/2014b]
1390S	Worksheet S-1, Part II, column 1, line 15, must contain a response of "1" or "2". If the response in column 1 is "2", then column 2 must have an amount greater than zero, and vice versa. [10/01/2014b]
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. [10/01/2014]
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. [10/01/2014b]
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. [10/01/2014b]
1420S	If Worksheet S-2, column 1, line 3 is "N", then Worksheet A-2-1 must not be present. [10/01/2014b]
1430S	If Worksheet S-2, column 1, line 3 is "Y", then Worksheet A-2-1, Part I, columns 4 or 5, sum of lines 1 through 4 must not equal zero, and Worksheet A-2-1, 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. [10/01/2014b]
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. [10/01/2014b]
1450S	Worksheet S-3, Part I, columns 1 through 4, lines 1 through 6, and Worksheet S-3, Part III, columns 1 and 2, lines 16 through 29, must be equal to or greater than zero. [10/01/2014b]
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. [10/01/2010b]
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. [10/01/2014b]
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. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

I. Level I Edits (Minimum File Requirements - Cont.)

Edit	Condition
1000A	Worksheet A, columns 1, 2, and 7, line 100, must be greater than zero. [10/01/2014b]
1060A	For each amount on Worksheet A, column 7, lines 23 through 31, and line 33 that are greater than zero, the corresponding total visits on Worksheet B, Part I, column 2, lines 1 through 10 must also be greater than zero, and vice versa. [10/01/2014b]
1120A	For reclassifications reported on Worksheet A-1, all increases (column 4) must equal all decreases (column 7). [10/01/2014b]
1130A	For each line on Worksheet A-1, 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. [10/01/2014b]
1140A	Worksheet A-1, column 0 must have an explanation present on the first line for each reclassification code. [10/01/2014b]
1200A	For Worksheet A-2 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. [10/01/2014b]
1210A	For Worksheet A-2 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". [10/01/2014b]
1220A	Worksheet A-2-1, 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. [10/01/2014b]
1000B	Worksheet B, Part I, columns 1 through 12, lines 1 through 10, all amounts must be greater than or equal to zero. [10/01/2014b]
1010B	Worksheet B, Part I, column 2, lines 1 through 10 must be equal to the sum of columns 7 and 8, lines 1 through 10, for each line. [10/01/2014b]
1020B	Worksheet B, Part I, column 2, line 11 must be equal to Worksheet S-3, Part I, column 5, sum of lines 2 and 4. [10/01/2014b]
1030B	Worksheet B, Part I, column 9, line 11 must be equal to Worksheet S-3, Part I, column 2, line 2. [10/01/2014b]
1040B	Worksheet B, Part I, column 10, line 11 must be equal to Worksheet S-3, Part I, column 2, line 4. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

II. Level II 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, notes, 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 of 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). [10/01/2014b]
2005	Only elements set forth in Table 3, with subscripts as appropriate, are required in the file. [10/01/2014b]
2010	The cost center code (positions 21 through 24 in type 2 records) must be a code from Table 5, Cost Center Coding, and each cost center code must be unique. [10/01/2014b]
2025	Only nonstandard cost center codes within a cost center category may be placed on lines 12, 69, and 79, and subscripts. [10/01/2014b]

ELECTRONIC REPORTING SPECIFICATIONS FOR FORM CMS-224-14
TABLE 6 - EDITS

II. Level II Edits (Potential Rejection Errors - Cont.)

Edit	Condition
2220S	Worksheet S-2, lines 17 through 19, all columns must be completed. [10/01/2014b]
2000F	Net income or loss on Worksheet F-1, column 2, line 33 should not equal zero. [10/01/2014b]

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; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-1298

FEDERALLY QUALIFIED HEALTH CENTER 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 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.

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

_____
Title

_____
Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII 1	
1	FQHC		1

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

FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-1 PART I

PART I - FEDERALLY QUALIFIED HEALTH CENTER 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:		Designation - Enter "R" for rural or "U" for urban:				3
4	Cost Reporting Period (mm/dd/yyyy)	From:	To:							4
5	Is this FQHC part of an entity that owns, leases or controls multiple FQHCs? 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 FQHC 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? 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		1 Y/N	2 Date Requested	3 Date Approved	4 Number of FQHCs	
13	Is this FQHC filing a consolidated cost report per CMS Pub. 100-04, chapter 9, §30.8? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, complete columns 2 through 4, and line 14, beginning with subscripted line 14.01. If column 1 is no, leave line 14 blank. (see instructions)					13

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

FQHC Operations		1	2	3	
15	What type of organization is this FQHC? If you operate as more than one sub-type of an organization enter only the applicable alpha characters in column 2. (see instructions)				15
16	Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? If this is a consolidated cost report, did the FQHC reported on line 1, column 2 receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. (complete line 17)				16
17	If the response to line 16 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.				17

Medical Malpractice					
18	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.				18
19	Is this FQHC legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.				19
20	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.				20
		Premiums	Paid Losses	Self Insurance	
21	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.				21
22	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than the Administrative and General cost center? Enter "Y" for yes or "N" for no. (see instructions)				22

Interns and Residents					
23	Is this FQHC 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.				23
24	Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.				24
25	Did this FQHC receive a Primary Care Residency Expansion (PCRE) grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding and in column 3, enter the total number of visits performed by residents funded by the PCRE grant in this cost reporting period. (see instructions)				25
26	Did this FQHC receive a Teaching Health Center development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)				26

Capital Related Costs - Ownership/Lease of Building					
27	Do you own or lease the building or office space occupied by your FQHC? Enter "1" for owned or "2" for leased in column 1. If you enter "2" in column 1, enter the amount of rent/lease expense in column 2.				27

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

PART II - FEDERALLY QUALIFIED HEALTH CENTER CONSOLIDATED COST REPORT PARTICIPANT 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:		Designation - Enter "R" for rural or "U" for urban:				3
	FQHC Operations						1	2	3	
4	What type of organization is this FQHC? If you operate as more than one sub-type of an organization enter only the applicable alpha characters in column 2. (see instructions)									4
5	Did this FQHC receive a grant under §330 of the PHS Act during this cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete line 6.									5
6	If the response to line 5 is yes, indicate in column 1, the type of HRSA grant that was awarded (see instructions). Enter the date of the grant award in column 2 and enter the grant award number in column 3. If you received more than one grant subscript this line accordingly.									6
	Medical Malpractice									
7	Did this FQHC submit an initial deeming or annual redeeming application for medical malpractice coverage under the FTCA with HRSA? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the effective date of coverage in column 2.									7
8	Is this FQHC legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.									8
9	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.									9
							Premiums	Paid Losses	Self Insurance	
10	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.									10
	Interns and Residents									
11	Is this FQHC 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.									11
12	Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.									12
13	Did this FQHC receive a Primary Care Residency Expansion (PCRE) grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of primary care FTE residents that your FQHC trained in this cost reporting period for which your FQHC received PCRE funding and in column 3, enter the total number of visits performed by residents funded by the PCRE grant in this cost reporting period. (see instuctions)									13
14	Did this FQHC receive a Teaching Health Center development grant authorized under Part C of Title VII of the PHS Act from HRSA? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of FTE residents that your FQHC trained and received funding through your THC grant in this cost reporting period and in column 3, enter the total number of visits performed by residents funded by the THC grant in this cost reporting period. (see instructions)									14
	Capital Related Costs - Ownership/Lease of Building									
15	Do you own or lease the building or office space occupied by your FQHC? Enter "1" for owned or "2" for leased in column 1. If you enter "2" in column 1, enter the amount of rent/lease expense in column 2.									15

FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT QUESTIONNAIRE	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-2

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL FQHCs

	Provider Organization and Operation	Y/N 1	Date 2	V/I 3	
1	Has the FQHC 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 FQHC 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 FQHC involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)				3

	Financial Data and Reports	Y/N 1	Type 2	Date 3	Y/N 4	
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Enter Y or N, if N, see instructions. Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (mm/dd/yyyy) Column 4: Are the cost report total expenses and total revenues different from those on the filed 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 Intern and Resident Costs on Worksheet A? If yes, see instructions.			7

	Bad Debts	Y/N 1	
8	Is the FQHC seeking reimbursement for bad debts? If yes, see instructions.		8
9	If line 8 is yes, did the FQHC'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 FQHC's 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 FQHC'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

FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART I

PART I - FEDERALLY QUALIFIED HEALTH CENTER 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

FEDERALLY QUALIFIED HEALTH CENTER DATA	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET S-3 PART II & III

PART II - FEDERALLY QUALIFIED HEALTH CENTER CONTRACT LABOR AND BENEFIT COST

		Contract Labor	Benefit Cost	
		1	2	
1	Total facility contract labor and benefit cost			1
2	Physician			2
3	Physician Assistant			3
4	Nurse Practitioner			4
5	Visiting Registered Nurse			5
6	Visiting Licensed Practical Nurse			6
7	Certified Nurse Midwife			7
8	Clinical Psychologist			8
9	Clinical Social Worker			9
10	Laboratory Technician			10
11	Reg Dietician/Cert DSMT/MNT Educator			11
12	Physical Therapist			12
13	Occupational Therapist			13
14	Other Allied Health Personnel			14
15	Interns & Residents			15

PART III - FEDERALLY QUALIFIED HEALTH CENTER EMPLOYEE DATA

Enter the number of hours in your normal work week _____		Number of Employees (Full Time Equivalent)			
		Staff	Contract	Total	
		1	2	3	
16	Physician				16
17	Physician Assistant				17
18	Nurse Practitioner				18
19	Registered Nurse				19
20	Licensed Practical Nurse				20
21	Certified Nurse Midwife				21
22	Clinical Psychologist				22
23	Clinical Social Worker				23
24	Laboratory Technician				24
25	Reg Dietician/Cert DSMT/MNT Educator				25
26	Physical Therapist				26
27	Occupational Therapist				27
28	Other Allied Health Personnel				28
29	Interns & Residents				29

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

		COST CENTER DESCRIPTIONS (omit cents)	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	
		GENERAL SERVICE COST CENTERS								
1	0100	Cap Rel Costs-Bldg and Fix								1
2	0200	Cap Rel Costs-Mvble Equip								2
3	0300	Employee Benefits								3
4	0400	Administrative & General Services								4
5	0500	Plant Operation and Maintenance								5
6	0600	Janitorial								6
7	0700	Medical Records								7
8		Subtotal - Administrative Overhead								8
9	0900	Pharmacy								9
10	1000	Medical Supplies								10
11	1100	Transportation								11
12	1200	Other General Service (specify)								12
13		Subtotal - Total Overhead								13
		DIRECT CARE COST CENTERS								
23	2300	Physician								23
24	2400	Physician Services Under Agreement								24
25	2500	Physician Assistant								25
26	2600	Nurse Practitioner								26
27	2700	Visiting Registered Nurse								27
28	2800	Visiting Licensed Practical Nurse								28
29	2900	Certified Nurse Midwife								29
30	3000	Clinical Psychologist								30
31	3100	Clinical Social Worker								31
32	3200	Laboratory Technician								32
33	3300	Reg Dietician/Cert DSMT/MNT Educator								33
34	3400	Physical Therapist								34
35	3500	Occupational Therapist								35
36	3600	Other Allied Health Personnel								36
37		Subtotal - Direct Patient Care Services								37

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

		COST CENTER DESCRIPTIONS (omit cents)	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	
REIMBURSABLE PASS THROUGH COSTS										
47	4700	Allowable GME Costs								47
48	4800	Pneumococcal Vaccines & Med Supplies								48
49	4900	Influenza Vaccines & Med Supplies								49
50		Subtotal - Reimbursable Pass through Costs								50
OTHER FQHC SERVICES										
60	6000	Medicare Excluded Services								60
61	6100	Diagnostic & Screening Lab Tests								61
62	6200	Radiology - Diagnostic								62
63	6300	Prosthetic Devices								63
64	6400	Durable Medical Equipment								64
65	6500	Ambulance Services								65
66	6600	Telehealth								66
67	6700	Drugs Charged to Patients								67
68	6800	Chronic Care Management								68
69	6900	Other (Specify)								69
70		Subtotal - Other FQHC Services								70
NONREIMBURSABLE COST CENTERS										
77	7700	Retail Pharmacy								77
78	7800	Nonallowable GME Costs								78
79	7900	Other Nonreimbursable (Specify)								79
80		Subtotal - Non-Reimbursable Costs								80
100		TOTAL (sum of lines 13, 37, 50, 70 and 80)								100

RECLASSIFICATIONS | CCN: _____ | PERIOD: FROM: _____ TO: _____ | WORKSHEET A-1

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES			DECREASES			
			COST CENTER	LINE #	AMOUNT	COST CENTER	LINE #	AMOUNT	
		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
100	Total reclassifications								100

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

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-2

	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	1	1
2	Investment income - movable equipment (chapter 2)			Movable Equipment	2	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-2-1				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	1	11
12	Depreciation - movable equipment			Movable Equipment	2	12
13	RCE adjustment to teaching physicians' cost			Allowable GME Costs	47	13
14	Other adjustments (specify) (3)					14
50	TOTAL (sum of lines 1 thru 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 thru 49 and subscripts thereof.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET A-2-1

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 column 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 column 6, line 5 to Worksheet A-2, 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 that you furnish the information requested under Part B 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 FQHC.
B. Corporation, partnership, or other organization has financial interest in FQHC.
C. FQHC has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of FQHC or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of FQHC and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in FQHC.
G. Other (financial or non-financial) specify _____

CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET B PARTS I & II

PART I - CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COST PER VISIT

	Positions	From Wkst. A, col. 7, line:	Direct Cost by Practitioner from Wkst. A	Total Medical & Mental Health Visits by Practitioner	Other Direct Care Costs & Pharmacy Costs (see instructions)	General Service Cost (see instructions)	Total Costs by Practitioner	Average Cost Per Visit by Practitioner	Total Visits: Medical Visits by Practitioner	Total Visits: Mental Health Visits by Practitioner	Title XVIII Visits: Medical Visits by Practitioner	Title XVIII Visits: Mental Health Visits by Practitioner	Title XVIII Costs: Medical Cost by Practitioner	Title XVIII Costs: Mental Health Cost by Practitioner	
			1	2	3	4	5	6	7	8	9	10	11	12	
1	Physician	23													1
2	Physician Services Under Agreement	24													2
3	Physician Assistant	25													3
4	Nurse Practitioner	26													4
5	Visiting Registered Nurse	27													5
6	Visiting Licensed Practical Nurse	28													6
7	Certified Nurse Midwife	29													7
8	Clinical Psychologist	30													8
9	Clinical Social Worker	31													9
10	Reg Dietician/Cert DSMT/MNT Educator	33													10
11	Totals														11
12	Unit Cost Multiplier														12
13	Total Cost Per Visit														13

PART II - CALCULATION OF ALLOWABLE DIRECT GRADUATE MEDICAL EDUCATION COSTS

		Total Cost (from Wkst. A col. 7, line 47)	Total I & R Visits	Title XVIII I & R Visits	Ratio of Title XVIII Visits to Total Visits	Allowable Title XVIII Direct GME Costs	
		1	2	3	4	5	
14	Allowable GME Costs						14

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, sum of lines 23, and 25 through 36)			1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			3
4	Vaccines and related medical supplies cost (from Worksheet A, column 7, lines 48 and 49, respectively)			4
5	Direct cost of pneumococcal and influenza vaccine (line 3 + line 4)			5
6	Total direct cost of the FQHC (from Worksheet A, column 7, line 100, minus Worksheet A, column 7, line 8)			6
7	Total administrative overhead (from Worksheet A, column 7, line 8)			7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 / line 6)			8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			9
10	Total cost of pneumococcal and influenza vaccine and their administration (sum of lines 5 and 9)			10
11	Total number of pneumococcal and influenza vaccine injections (from your records)			11
12	Cost per pneumococcal and influenza vaccine injection (line 10 / line 11)			12
13	Number of pneumococcal and influenza vaccine injections administered to Medicare beneficiaries			13
14	Cost of pneumococcal and influenza vaccines and their administration costs furnished to Medicare beneficiaries (line 12 x line 13)			14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 10)			15
16	Total Medicare cost of pneumococcal and influenza vaccines and their administration costs (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet E, line 3)			16

CALCULATION OF REIMBURSEMENT SETTLEMENT	CCN: _____	PERIOD: FROM: _____ TO: _____	WORKSHEET E

1	FQHC PPS Amount		1
2	Direct graduate medical education payments (from Worksheet B, Part II, line 14, column 5)		2
3	Medicare cost of pneumococcal and influenza vaccine and their administration (From Worksheet B-1, line 16)		3
4	Medicare advantage supplemental payments (for information only)		4
5	Total (sum of amounts on lines 1 through 3)		5
6	Primary payer payments		6
7	Total amount payable for program beneficiaries (line 5 minus line 6)		7
8	Coinsurance billed to program beneficiaries		8
9	Net Medicare reimbursement excluding bad debts (line 7 minus line 8)		9
10	Allowable bad debts (see instructions)		10
11	Adjusted reimbursable bad debts (see instructions)		11
12	Allowable bad debts for dual eligible beneficiaries (see instructions)		12
13	Subtotal (line 9 plus line 11)		13
14	Other adjustments (specify) (see instructions)		14
15	Amount due FQHC prior to the sequestration adjustment (see instructions)		15
16	Sequestration adjustment (see instructions)		16
17	Amount due FQHC after sequestration adjustment (see instructions)		17
18	Interim payments		18
19	Tentative settlement (for contractor use only)		19
20	Balance due FQHC/program (line 17 minus lines 18 and 19)		20
21	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		21

ANALYSIS OF PAYMENTS TO THE FEDERALLY QUALIFIED HEALTH CENTER FOR SERVICES RENDERED	CCN:	PERIOD: FROM: TO:	WORKSHEET E-1

	Description			Part B mm/dd/yyyy 1	Part B Amount 2	
1	Total interim payments paid to FQHC					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. E, line 18)					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 FQHC to program, show the amount and date on which the FQHC agrees to the amount of repayment even though total repayment is not accomplished until a later date.

STATEMENT OF REVENUE AND EXPENSES	CCN: _____	PERIOD From: _____ To: _____	WORKSHEET F-1

		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1	2	3	4	
1	Gross patient revenues					1
				1	2	
2	Less: Allowances and discounts on patients' accounts					2
3	Net patient revenues (Line 1 minus line 2)					3
4	Operating expenses (From Worksheet A, column 3, line 100)					4
5	Additions to operating expenses (specify)					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 5 through 9)					10
11	Subtractions from operating expenses (specify)					11
12						12
13						13
14						14
15						15
16	Total subtractions (sum of lines 11 through 15)					16
17	Total operating expenses (sum of line 4, plus line 10, minus line 16)					17
18	Net income from service to patients (Line 3 minus line 17)					18
	Other income:					
19	Contributions, donations, bequests, etc.					19
20	Income from investments					20
21	Purchase discounts					21
22	Rebates and refunds of expenses					22
23	Sale of Medical and Nursing Supplies to other than patients					23
24	Sale of durable medical equipment to other than patients					24
25	Sale of drugs to other than patients					25
26	Sale of medical records and abstracts					26
27	Government Appropriations					27
28	Other revenues (specify)					28
29						29
30						30
31						31
32	Total Other Income (Sum of lines 19 through 31)					32
33	Net Income or Loss for the period (Line 18 plus line 32)					33