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

**WORKSHEET S - PART I**

FOR INTERMEDIARY USE

THIS REPORT IS REQUIRED BY LAW (42 USC, 1395G: CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL PAYMENTS MADE DURING THE REPORTING PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g)

DATE RECEIVED _____

INTERMEDIARY NUMBER

**PART I - STATISTICAL DATA** ☐ PROJECTED COST REPORT ☐ ACTUAL/FINAL COST REPORT

FACILITY NAME AND ADDRESS:

COUNTY:

FACILITY NUMBER: _____ DESIGNATION: _____ REPORTING PERIOD FROM: TO:

A. VOLUNTARY NON-PROFIT
_____ CORPORATION
_____ OTHER (SPECIFY)

B. PROPRIETARY
_____ INDIVIDUAL _____ PARTNERSHIP
_____ CORP _____ OTHER (SPECIFY)

C. GOVERNMENT
_____ FED _____ COUNTY
_____ STATE _____ OTHER
_____ CITY _____ TOWN COMMISSION

RURAL HEALTH CLINIC OWNED BY: _____

*OTHER RURAL HEALTH CLINICS, PROVIDERS OF SERVICES THAT ARE OWNED OR RELATED THROUGH COMMON OWNERSHIP OR CONTROL TO THE INDIVIDUAL OR ENTITIES LISTED BELOW*

NAMES OF PHYSICIANS FURNISHING SERVICES AT THE RURAL HEALTH CLINIC OR UNDER AGREEMENT, AND MEDICARE BILLING NUMBERS

| NAME | BILLING NUMBER |
|---|---|
| | |
| | |
| | |
| | |
| | |

SUPERVISORY PHYSICIANS

| NAME | HRS OF SUPERVISION FOR PERIOD |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

EXHIBIT A

PROVIDER NAME: _____

PROVIDER NUMBER: _____ FYE: _____

| | | VISITS (ENCOUNTERS) 1 | TOTAL PROGRAM CHARGES 2 | PAID BY PRIMARY CARRIER & PATIENT PAY 3 | AMOUNT RECEIVED FROM INTERMEDIARY 4 | CASH ADVANCES 5 | TOTAL PAYMENTS 6 |
|---|---|---|---|---|---|---|---|
| 1 | Paid by Intermediary during the fiscal period on weekly remittances at applicable tentative rate. | | | | | | |
| a | Clinic Encounters | | | | | | |
| b | HMO Clinic Encounters | | | | | | |
| c | Inpatient Hospital Encounters | | | | | | |
| d | HMO Inpatient Hospital Encounters | | | | | | |
| e | Dental Encounters | | | | | | |
| f | HMO Dental Encounters | | | | | | |
| 2 | (Deduct): Items applicable to services rendered but not paid during prior period (should be identical to amounts added to prior years report). | | | | | | |
| 3 | Add: Items applicable to services rendered but not paid in current fiscal period. | | | | | | |
| 4 | Total Program Visits | | | | | | |
| 5 | Total Program Charges | | | | | | |
| 6 | Amount Received from Primary Carrier/Patient Pay | | | | | | |
| 7 | Amount Received from Intermediary | | | | | | |

CASH ADVANCES:

| DATE | CLINIC | HMO |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| TOTAL | | |

| | | | | |
|---|---|---|---|---|
| | PROVIDER NAME: | | | |
| | **DETERMINATION OF MEDICAID REIMBURSEMENT** | PROVIDER #: | | EXHIBIT C |
| | | FYE: | | PART I |
| | PART I - DETERMINATION OF RATE FOR RHC/FQHC SERVICES | | | AMOUNT |
| 1 | Total Allowable Costs (W/S B, Part II Line 16) | | | |
| 2 | Cost for Pneumococcal and Influenza Vaccine and Its(Their) Administration (From Supplemental W/S B-1, Line 15) | | | |
| 3 | Total Allowable Cost Excluding Pneumococcal and Influenza Vaccine (Line 1 - Line 2) | | | |
| 4 | Greater of Minimum or Actual Visits by Health Care Staff (W/S B, Part I, Col 5, Line 8) | | | |
| 5 | Physicians Visits Under Agreements (W/S B, Part I, Col 5, Line 9) | | | |
| 6 | Total Adjusted Visits (Line 4 + Line 5) | | | |
| 7 | Adjusted Cost Per Visit (Line 3/Line 6) | | | |
| | | 1 | 2 | |
| 8 | Maximum Rate Per Visit (see instructions) | | | |
| 9 | Rate for Medicare Covered Visits (Lesser of Line 7 or Line 8) | | | |
| 10 | Number of Months in Rate Period | | | |

| PROVIDER NAME: | | | |
|---|---|---|---|
| **DETERMINATION OF MEDICAID PAYMENT CLINIC** | PROVIDER #: _____ FYE: _____ | | EXHIBIT C PART II |
| PART II - DETERMINATION OF TOTAL PAYMENT | 1 | 2 | 3 TOTAL |
| 10 Rate for Medicaid Covered Visits (Part I, Line 9) | | | |
| 11 Medicaid Clinic Covered Visits Excluding Clinical Psychologists and Clinical Social Workers (from Intermediary Records) | | | |
| 12 Medicaid Cost Excluding Costs for Clinical Psychologists and Clinical Social Workers (Line 10 x Line 11) | | | |
| 13 Medicaid Covered Visits for Clinical Psychologists and Clinical Social Workers (from Intermediary Records) | | | |
| 14 Medicaid Covered Cost for Clinical Psychologists and Clinical Social Workers (Line 10 x Line 13) | | | |
| 15 Limit Adjustment | | | |
| 16 Total Medicaid Cost (Line 12 + Line 15) | | | |
| 17 Less: Beneficiary Deductible (from Intermediary Records) | | | |
| 18 Net Medicaid Cost Excluding Pneumococcal and Influenza Vaccine and Its(Their) Administration (Line 16 - Line 17) | | | |
| 19 Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (Line 18, Col 3) 100% | | | |
| 20 Medicaid Cost of Pneumococcal and Influenza Vaccine and Its(Their) Administration (from Supplemental W/S B-1, Line 16) | | | |
| 21 Total Reimbursable Medicaid Cost (Line 19 + Line 20) | | | |
| 22 Less Clinic Payments to RHC/FQHC During Reporting Period (Exhibit A, Line 1a, Col 6) | | | |
| 23 Balance Due From(To) Program Exclusive of Bad Debts (Line 21 - Line 22) | | | |
| 24 Total Reimbursable Bad Debts (from Part III, Line 33) | | | |
| 24A Medicaid Costs (Supplemental Exhibit C - Clinic, Line 29) | | | |
| 25 Total Amount Due From(To) Program (Line 23 + Line 24) | | | |

PROVIDER NAME: _____ SUPPLEMENTAL EXHIBIT C

PROVIDER #: _____

FYE: _____

CALCULATION OF REIMBURSABLE COSTS FOR SERVICES COVERED BY MEDICAID
BUT NOT BY MEDICARE

**CLINIC**

| | | |
|---|---|---|
| 1 | COST OF ALL SERVICES - EXCLUDING OVERHEAD (W/S B, LINE 12) | |
| 2 | TOTAL OVERHEAD (W/S B, LINE 14) | |
| | **BABYCARE COST ALLOCATION (MEDICAID ONLY)** | |
| 3 | TOTAL MEDICAID VISITS (ENCOUNTERS) FROM PROVIDER'S RECORDS | |
| 4 | TOTAL DIRECT BABYCARE COST (W/S A, LINE 55, COL 7) | |
| 5 | PERCENTAGE OF BABYCARE SERVICES - EXCLUDING OVERHEAD (LINE 4/LINE 1) | |
| 6 | OVERHEAD APPLICABLE TO BABY CARE SERVICE (LINE 2 X LINE 5) | |
| 7 | TOTAL MEDICAID BABYCARE COSTS (LINE 4 + LINE 6) | |
| 8 | BABYCARE COST PER VISIT (ENCOUNTER) (LINE 7/LINE 3) | |
| | **DENTAL COST ALLOCATION** | |
| 9 | TOTAL DENTAL VISITS (ENCOUNTERS) FROM PROVIDER'S RECORDS | |
| 10 | TOTAL MEDICAID DENTAL VISITS (ENCOUNTERS) | |
| 11 | TOTAL DIRECT DENTAL COSTS (W/S A, LINE 53, COL 7) | |
| 12 | PERCENTAGE OF DENTAL SERVICES - EXCLUDING OVERHEAD (LINE 11/LINE 1) | |
| 13 | OVERHEAD APPLICABLE TO DENTAL SERVICES (LINE 2 X LINE 12) | |
| 14 | TOTAL DENTAL COSTS (LINE 11 + LINE 13) | |
| 15 | DENTAL COST PER VISIT (ENCOUNTER) (LINE 14/LINE 9) | |
| 16 | TOTAL MEDICAID DENTAL COSTS (LINE 10 X LINE 15) | |
| | **RADIOLOGY COST ALLOCATION** | |
| 17 | TOTAL DIRECT X-RAY COSTS (W/S A, LINE 54, COL 7) | |
| 18 | PERCENTAGE OF X-RAY SERVICES - EXCLUDING OVERHEAD (LINE 17/LINE 1) | |
| 19 | OVERHEAD APPLICABLE TO X-RAY SERVICES (LINE 18 X LINE 2) | |
| 20 | TOTAL X-RAY COSTS (LINE 17 + LINE 19) | |
| 21 | RATIO OF MEDICAID CLINIC COSTS (EXH C-CLINIC, LINE 21)/TOTAL CLINIC COSTS (W/S B, LINE 16) | |
| 22 | X-RAY COST APPLICABLE TO MEDICAID (LINE 20 X LINE 21) | |
| | **INPATIENT HOSPITAL** | |
| 23 | TOTAL INPATIENT HOSPITAL COSTS (W/S A LINE 56, COLUMN 7) | |
| 24 | PERCENTAGE OF OTHER SERVICES - EXCLUDING OVERHEAD (LINE 23/LINE 1) | |
| 25 | OVERHEAD APPLICABLE TO OTHER SERVICES (LINE 24 X LINE 2) | |
| 26 | TOTAL OTHER REIMBURSABLE COSTS (LINE 23 + LINE 25) | |
| 27 | MEDICAID PERCENTAGE (MEDICAID INPATIENT VISITS/TOTAL INPATIENT VISITS) | |
| 28 | TOTAL OTHER SERVICES APPLICABLE TO MEDICAID (LINE 26 X LINE 27) | |
| 29 | TOTAL ADDITIONAL COSTS REIMBURSABLE BY MEDICAID (LINES 7 + 16 + 22 + 28) (TRANSFER THIS AMOUNT TO EXH C, PART II - CLINIC, LINE 27) | |

MEDICAID INPATIENT HOSPITAL ENCOUNTERS _____

TOTAL INPATIENT ENCOUNTERS _____

MEDICAID UTILIZATION _____

| PROVIDER NAME: | | | |
|---|---|---|---|
| **DETERMINATION OF MEDICAID PAYMENT HMO** | PROVIDER #: _____ FYE: _____ | | EXHIBIT C PART II |
| PART II - DETERMINATION OF TOTAL PAYMENT | 1 | 2 | 3 TOTAL |
| 10 Rate for Medicaid Covered Visits (Part I, Line 9) | | | |
| 11 Medicaid HMO Covered Visits Excluding Clinical Psychologists and Clinical Social Workers (from Intermediary Records) | | | |
| 12 Medicaid Cost Excluding Costs for Clinical Psychologists and Clinical Social Workers (Line 10 x Line 11) | | | |
| 13 Medicaid Covered Visits for Clinical Psychologists and Clinical Social Workers (from Intermediary Records) | | | |
| 14 Medicaid Covered Cost for Clinical Psychologists and Clinical Social Workers (Line 10 x Line 13) | | | |
| 15 Limit Adjustment | | | |
| 16 Total Medicaid Cost (Line 12 + Line 15) | | | |
| 17 Less: Beneficiary Deductible (from Intermediary Records) | | | |
| 18 Net Medicare Cost Excluding Pneumococcal and Influenza Vaccine and Its(Their) Administration (Line 16 - Line 17) | | | |
| 19 Reimbursable Cost of RHC/FQHC Services, Other Than Pneumococcal and Influenza Vaccine (Line 18, Col 3) 100% | | | |
| 20 Medicaid Cost of Pneumococcal and Influenza Vaccine and Its(Their) Administration (from Supplemental W/S B-1, Line 16) | | | |
| 21 Total Reimbursable Medicaid Cost (Line 19 + Line 20) | | | |
| 22 Less HMO Payments to RHC/FQHC During Reporting Period (Exhibit A, Line 1b, Col 6) | | | |
| 23 Balance Due From(To) Program Exclusive of Bad Debts (Line 21 - Line 22) | | | |
| 24 Total Reimbursable Bad Debts (from Part III, Line 33) | | | |
| 24A Medicaid Costs (Supplemental W/S C, Line 29) | | | |
| 25 Total Amount Due From(To) Program (Line 23 + Line 24) | | | |

PROVIDER NAME: _____ SUPPLEMENTAL EXHIBIT C

PROVIDER #: _____

FYE: _____

CALCULATION OF REIMBURSABLE COSTS FOR SERVICES COVERED BY MEDICAID
BUT NOT BY MEDICARE
**HMO**

| | | |
|---|---|---|
| 1 | COST OF ALL SERVICES - EXCLUDING OVERHEAD (W/S B, LINE 12) | |
| 2 | TOTAL OVERHEAD (W/S B, LINE 14) | |
| | **BABYCARE COST ALLOCATION (MEDICAID ONLY)** | |
| 3 | TOTAL MEDICAID VISITS (ENCOUNTERS) FROM PROVIDER'S RECORDS | |
| 4 | TOTAL DIRECT BABYCARE COST (W/S A, LINE 55, COL 7) | |
| 5 | PERCENTAGE OF BABYCARE SERVICES - EXCLUDING OVERHEAD (LINE 4/LINE 1) | |
| 6 | OVERHEAD APPLICABLE TO BABY CARE SERVICE (LINE 2 X LINE 5) | |
| 7 | TOTAL MEDICAID BABYCARE COSTS (LINE 4 + LINE 6) | |
| 8 | BABYCARE COST PER VISIT (ENCOUNTER) (LINE 7/LINE 3) | |
| | **DENTAL COST ALLOCATION** | |
| 9 | TOTAL DENTAL VISITS (ENCOUNTERS) FROM PROVIDER'S RECORDS | |
| 10 | TOTAL MEDICAID DENTAL VISITS (ENCOUNTERS) | |
| 11 | TOTAL DIRECT DENTAL COSTS (W/S A, LINE 53, COL 7) | |
| 12 | PERCENTAGE OF DENTAL SERVICES - EXCLUDING OVERHEAD (LINE 11/LINE 1) | |
| 13 | OVERHEAD APPLICABLE TO DENTAL SERVICES (LINE 2 X LINE 12) | |
| 14 | TOTAL DENTAL COSTS (LINE 11 + LINE 13) | |
| 15 | DENTAL COST PER VISIT (ENCOUNTER) (LINE 14/LINE 9) | |
| 16 | TOTAL MEDICAID DENTAL COSTS (LINE 10 X LINE 15) | |
| | **RADIOLOGY COST ALLOCATION** | |
| 17 | TOTAL DIRECT X-RAY COSTS (W/S A, LINE 54, COL 7) | |
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| 20 | TOTAL X-RAY COSTS (LINE 17 + LINE 19) | |
| 21 | RATIO OF MEDICAID CLINIC COSTS (EXH C-HMO, LINE 21)/TOTAL CLINIC COSTS (W/S B, | |
| 22 | X-RAY COST APPLICABLE TO MEDICAID (LINE 20 X LINE 21) | |
| | **INPATIENT HOSPITAL** | |
| 23 | TOTAL INPATIENT HOSPITAL COSTS (W/S A LINE 56, COLUMN 7) | |
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| 27 | MEDICAID PERCENTAGE (MEDICAID INPATIENT VISITS/TOTAL INPATIENT VISITS) | |
| 28 | TOTAL OTHER SERVICES APPLICABLE TO MEDICAID (LINE 26 X LINE 27) | |
| 29 | TOTAL ADDITIONAL COSTS REIMBURSABLE BY MEDICAID (LINES 7 + 16 + 22 + 28) (TRANSFER THIS AMOUNT TO W/S C, PART II - HMO, LINE 27) | |

MEDICAID HMO INPATIENT HOSPITAL ENCOUNTERS _____

TOTAL INPATIENT ENCOUNTERS _____

MEDICAID UTILIZATION _____