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
APPROVAL EXPIRES 03-31-2022

GRACE CLINIC HEALTH PROFESSIONAL	Period:	Run Date Time:	11/29/2021 11:51 am
	From: 12/01/2020	MCRIF32	**224-14**
CCN: 15-1083	To: 06/30/2021	Version:	4.3.172.1

FEDERALLY QUALIFIED HEALTH CENTER COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared cost report
3. [0] If this is an amended cost report enter the number of times the provider resubmitted this cost report.
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without audit
   (3) Settled with audit
   (4) Reopened
   (5) Amended
6. Date Recieved:
7. Contractor No.:
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN
10. NPR Date:
11. Contractors Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter the number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GRACE CLINIC HEALTH PROFESSIONAL, {Provider Name(s) and Number(s)} for the cost reporting period beginning 12/01/2020 and ending 06/30/2021 and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	*Tracie Session*		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Printed Name	TRACIE SESSION			2
3	Title	INTERIM CFO			3
4	Signature Date	(Dated when report is electronically signed.)			4

PART III - SETTLEMENT SUMMARY

		Title XVIII	
		1.00	
1.00	FQHC	0	1.00

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

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FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

Worksheet S-1
Part I

PART I - FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

		Site Name					Provider CCN	CBSA	Date Certified	Type of control (see instructions)	
		1.00					2.00	3.00	4.00	5.00	
1.00	Site Name:	GRACE CLINIC HEALTH PROFESSIONAL					15-1083	99915	10/01/2020	1	1.00
2.00	Street:	622 EIGHTH AVENUE	P.O. Box:								2.00
3.00	City:	TERRE HAUTE	State:	IN	Zip Code:	47804	County:	VIGO	Designation - Enter "R" for rural or "U" for urban:	R	3.00
4.00	Cost Reporting Period (mm/dd/yyyy)		From:	12/01/2020	To:	06/30/2021					4.00
5.00	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.								N		5.00
6.00	Name of Entity:										6.00
7.00	Street:		P.O. Box:		HRSA Award Number:						7.00
8.00	City:		State:		Zip Code:						8.00
9.00	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.								N		9.00
10.00	Name of Chain Organization										10.00
11.00	Street:		P.O. Box:		Home Office CCN:						11.00
12.00	City:		State:		Zip Code:						12.00

Consolidated Cost Report

		Y/N	Date Requested	Date Approved	Number of FQHCs	
		1.00	2.00	3.00	4.00	
13.00	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)	N			0	13.00

	Site Name	CCN	CBSA	Date Requested	Date Approved	
	1.00	2.00	3.00	4.00	5.00	
14.00	FQHC Site Information:					14.00

FQHC Operations

		1.00	2.00	3.00	
15.00	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)	3	A		15.00
16.00	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)	Y			16.00
17.00	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.	1	07/08/2021	L2CCS423790100	17.00

Medical Malpractice

18.00	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.	N			18.00
19.00	Does this FQHC carry commercial malpractice insurance? Enter "Y" for yes or "N" for no.	N			19.00
20.00	Is the malpractice insurance a claims-made or occurrence policy? Enter "1" for claims-made or "2" for occurrence policy.	0			20.00
		Premiums	Paid Losses	Self Insurance	
21.00	List amounts of malpractice premiums, paid losses or self-insurance in the applicable columns.	0	0	0	21.00
22.00	Are malpractice premiums, paid losses or self-insurance reported in a cost center other than Administrative and General? Enter "Y" for yes or "N" for no. (see instructions)	N			22.00

Interns and Residents

23.00	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	N			23.00
24.00	Is this FQHC involved in training residents in an unapproved GME program? Enter "Y" for yes or "N" for no.	N			24.00
25.00	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)	N	0.00	0	25.00
26.00	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)	N	0.00	0	26.00

Capital Related Costs - Ownership/Lease of Building

27.00	Do you own or lease the building or office space occupied by your FQHC, or is the building or office space provided at no cost to the FQHC? Enter "1" for owned, "2" for leased, or "3" for space provided at no cost in column 1. If you enter "2" in column 1, enter the amount of rent/lease expense in column 2.	1	0		27.00

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FEDERALLY QUALIFIED HEALTH CENTER IDENTIFICATION DATA

Worksheet S-1
Part I

		1.00	
Contract Labor Cost			
28.00	Do you use contract labor to provide medical and/or mental health services to your patients? Enter "Y" for yes or "N" for no in column 1.	N	28.00

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FEDERALLY QUALIFIED HEALTH CENTER REIMBURSEMENT QUESTIONNAIRE **Worksheet S-2**

Provider Organization and Operation

		Y/N	Date	V/I	
		1.00	2.00	3.00	
1.00	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)	N			1.00
2.00	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)	N			2.00
3.00	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)	N			3.00

Financial Data and Reports

		Y/N	Type	Date	Y/N	
		1.00	2.00	3.00	4.00	
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? 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?	N			N	4.00

Approved Educational Activities

		Y/N	Y/N	
		1.00	2.00	
5.00	Are costs for Intern-Resident programs claimed on the current cost report?	N		5.00
6.00	Was an Intern-Resident program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		6.00
7.00	Are GME costs directly assigned to cost centers other than Allowable GME Costs on Worksheet A? If yes, see instructions.	N		7.00

Bad Debts

		Y/N	
		1.00	
8.00	Is the FQHC seeking reimbursement for bad debts? If yes, see instructions.	N	8.00
9.00	If line 8 is yes, did the FQHC's bad debt collection policy change during this cost reporting period? If yes, submit copy.		9.00
10.00	If line 8 is yes, were patient coinsurance amounts waived? If yes, see instructions.		10.00

PS&R Report Data

		Y/N	Date	
		1.00	2.00	
11.00	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)	Y	11/09/2021	11.00
12.00	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)	N		12.00
13.00	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.	N		13.00
14.00	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.	N		14.00
15.00	If line 11 or 12 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		15.00
16.00	Was the cost report prepared using only the FQHC's records? If yes, see instructions.	N		16.00

Cost Report Preparer Contact Information

17.00	First Name:	TINA	Last name:	SEVERS	Title:	MANAGER	17.00
18.00	Employer	BLUE AND CO., LLC					18.00
19.00	Phone Number:	3177137946	Email Address:	TSEVERS@BLUEANDCO.COM			19.00

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FEDERALLY QUALIFIED HEALTH CENTER DATA

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	1.00	2.00	3.00	4.00	5.00	
1.00	Medical Visits (15-1083 - GRACE CLINIC HEALTH PROFESSIONAL)	15-1083	0	212	595	1	**808**	1.00
2.00	Total Medical Visits		**0**	**212**	**595**	**1**	**808**	2.00
3.00	Mental Health Visits (15-1083 - GRACE CLINIC HEALTH PROFESSIONAL)	15-1083	0	71	252	0	**323**	3.00
4.00	Total Mental Health Visits		**0**	**71**	**252**	**0**	**323**	4.00
5.00	Number of Visits Performed by Interns and Residents (15-1083 - GRACE CLINIC HEALTH PROFESSIONAL)	15-1083	0	0	0	0	**0**	5.00
6.00	Total Number of Visits Performed by Interns and Residents		**0**	**0**	**0**	**0**	**0**	6.00

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FEDERALLY QUALIFIED HEALTH CENTER DATA

Worksheet S-3
Parts II & III

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

		Contract Labor	Benefit Cost	
		1.00	2.00	
1.00	Total facility contract labor and benefit cost	**0**	**97,352**	1.00
2.00	Physician	0	35,418	2.00
3.00	Physician Assistant	0	0	3.00
4.00	Nurse Practitioner	0	44,570	4.00
5.00	Visiting Registered Nurse	0	0	5.00
6.00	Visiting Licensed Practical Nurse	0	0	6.00
7.00	Certified Nurse Midwife	0	0	7.00
8.00	Clinical Psychologist	0	0	8.00
9.00	Clinical Social Worker	0	2,206	9.00
10.00	Laboratory Technician	0	0	10.00
11.00	Reg Dietician/Cert DSMT/MNT Educator	0	0	11.00
12.00	Physical Therapist	0	0	12.00
13.00	Occupational Therapist	0	0	13.00
14.00	Other Allied Health Personnel	0	15,158	14.00
15.00	Interns & Residents		0	15.00

PART III - FEDERALLY QUALIFIED HEALTH CENTER EMPLOYEE DATA

		Number of Employees (Full Time Equivalent)			
	Enter the number of hours in your normal work week: 40.00	Staff	Contract	Total	
		1.00	2.00	3.00	
16.00	Physician (Enter the number of hours in your normal work week in column 0.)	0.61	0.00	**0.61**	16.00
17.00	Physician Assistant	0.00	0.00	**0.00**	17.00
18.00	Nurse Practitioner	1.72	0.00	**1.72**	18.00
19.00	Visiting Registered Nurse	0.00	0.00	**0.00**	19.00
20.00	Visiting Licensed Practical Nurse	0.00	0.00	**0.00**	20.00
21.00	Certified Nurse Midwife	0.00	0.00	**0.00**	21.00
22.00	Clinical Psychologist	0.00	0.00	**0.00**	22.00
23.00	Clinical Social Worker	0.11	0.00	**0.11**	23.00
24.00	Laboratory Technician	0.00	0.00	**0.00**	24.00
25.00	Reg Dietician/Cert DSMT/MNT Educator	0.00	0.00	**0.00**	25.00
26.00	Physical Therapist	0.00	0.00	**0.00**	26.00
27.00	Occupational Therapist	0.00	0.00	**0.00**	27.00
28.00	Other Allied Health Personnel	2.33	0.00	**2.33**	28.00
29.00	Interns & Residents	0.00		**0.00**	29.00

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

		Cost Center Description (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)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	0100	CAP REL COSTS-BLDG & FIX		10,552	10,552	0	10,552	0	**10,552**	1.00
2.00	0200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	0	**0**	2.00
3.00	0300	EMPLOYEE BENEFITS	0	135,883	135,883	-135,883	0	0	**0**	3.00
4.00	0400	ADMINISTRATIVE & GENERAL SERVICES	109,265	122,857	232,122	38,532	270,654	0	**270,654**	4.00
5.00	0500	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	0	**0**	5.00
6.00	0600	JANITORIAL	0	0	0	0	0	0	**0**	6.00
7.00	0700	MEDICAL RECORDS	0	0	0	0	0	0	**0**	7.00
8.00		SUBTOTAL - ADMINISTRATIVE OVERHEAD	**109,265**	**269,292**	**378,557**	**-97,351**	**281,206**	**0**	**281,206**	8.00
9.00	0900	PHARMACY	0	22,355	22,355	0	22,355	0	**22,355**	9.00
10.00	1000	MEDICAL SUPPLIES	0	26,297	26,297	0	26,297	0	**26,297**	10.00
11.00	1100	TRANSPORTATION	0	0	0	0	0	0	**0**	11.00
12.00	1200	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	0	**0**	12.00
13.00		SUBTOTAL - TOTAL OVERHEAD	**109,265**	**317,944**	**427,209**	**-97,351**	**329,858**	**0**	**329,858**	13.00
DIRECT CARE COST CENTERS										
23.00	2300	PHYSICIAN	100,435	0	100,435	35,418	135,853	0	**135,853**	23.00
24.00	2400	PHYSICIAN SERVICES UNDER AGREEMENT		0	0	0	0	0	**0**	24.00
25.00	2500	PHYSICIAN ASSISTANT	0	0	0	0	0	0	**0**	25.00
26.00	2600	NURSE PRACTITIONER	126,389	0	126,389	44,569	170,958	0	**170,958**	26.00
27.00	2700	VISITING REGISTERED NURSE	0	0	0	0	0	0	**0**	27.00
28.00	2800	VISITING LICENSED PRACTICAL NURSE	0	0	0	0	0	0	**0**	28.00
29.00	2900	CERTIFIED NURSE MIDWIFE	0	0	0	0	0	0	**0**	29.00
30.00	3000	CLINICAL PSYCHOLOGIST	0	0	0	0	0	0	**0**	30.00
31.00	3100	CLINICAL SOCIAL WORKER	6,255	0	6,255	2,206	8,461	0	**8,461**	31.00
32.00	3200	LABORATORY TECHNICIAN	0	0	0	0	0	0	**0**	32.00
33.00	3300	REG DIETICIAN/CERT DSMT/MNT EDUCATOR	0	0	0	0	0	0	**0**	33.00
34.00	3400	PHYSICAL THERAPIST	0	0	0	0	0	0	**0**	34.00
35.00	3500	OCCUPATIONAL THERAPIST	0	0	0	0	0	0	**0**	35.00
36.00	3600	OTHER ALLIED HEALTH PERSONNEL	42,984	0	42,984	15,158	58,142	0	**58,142**	36.00
37.00		SUBTOTAL - DIRECT PATIENT CARE SERVICES	**276,063**	**0**	**276,063**	**97,351**	**373,414**	**0**	**373,414**	37.00
REIMBURSABLE PASS THROUGH COSTS										
47.00	4700	ALLOWABLE GME COSTS	0	0	0	0	0	0	**0**	47.00
48.00	4800	PNEUMOCOCCAL VACCINES & MED SUPPLIES	0	0	0	0	0	0	**0**	48.00
49.00	4900	INFLUENZA VACCINES & MED SUPPLIES	0	0	0	0	0	0	**0**	49.00
49.10	4910	COVID-19 VACCINES & MED SUPPLIES	0	0	0	0	0	0	**0**	49.10
49.11	4911	MONOCLONAL ANTIBODY PRODUCTS	0	0	0	0	0	0	**0**	49.11
50.00		SUBTOTAL - REIMBURSABLE PASS THROUGH COSTS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	50.00
OTHER FQHC SERVICES										
60.00	6000	MEDICARE EXCLUDED SERVICES	0	0	0	0	0	0	**0**	60.00
61.00	6100	DIAGNOSTIC & SCREENING LAB TESTS	0	0	0	0	0	0	**0**	61.00
62.00	6200	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	0	**0**	62.00
63.00	6300	PROSTHETIC DEVICES	0	0	0	0	0	0	**0**	63.00
64.00	6400	DURABLE MEDICAL EQUIPMENT	0	0	0	0	0	0	**0**	64.00
65.00	6500	AMBULANCE SERVICES	0	0	0	0	0	0	**0**	65.00
66.00	6600	TELEHEALTH	0	0	0	0	0	0	**0**	66.00
67.00	6700	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	67.00
68.00	6800	CHRONIC CARE MANAGEMENT	0	0	0	0	0	0	**0**	68.00
69.00	6900	OTHER (SPECIFY)	0	0	0	0	0	0	**0**	69.00
70.00		SUBTOTAL - OTHER FQHC SERVICES	**0**	**0**	**0**	**0**	**0**	**0**	**0**	70.00
NONREIMBURSABLE COST CENTERS										
77.00	7700	RETAIL PHARMACY	0	0	0	0	0	0	**0**	77.00
78.00	7800	NONALLOWABLE GME COSTS	0	0	0	0	0	0	**0**	78.00
79.00	7900	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	0	**0**	79.00
80.00		SUBTOTAL - NON-REIMBURSABLE COSTS	**0**	**0**	**0**	**0**	**0**	**0**	**0**	80.00
100.00		TOTAL (SUM OF LINES 13, 37, 50, 70 AND 80)	**385,328**	**317,944**	**703,272**	**0**	**703,272**	**0**	**703,272**	100.00

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RECLASSIFICATIONS **Worksheet A-1**

	Increases			Decreases			
	Cost Center	Line No.	Amount (2)	Cost Center	Line No.	Amount (2)	
	2.00	3.00	4.00	5.00	6.00	7.00	
A - BENEFITS RECLASS							
1.00	ADMINISTRATIVE & GENERAL SERVICES	4.00	38,532	EMPLOYEE BENEFITS	3.00	135,883	1.00
2.00	PHYSICIAN	23.00	35,418		0.00	0	2.00
3.00	NURSE PRACTITIONER	26.00	44,569		0.00	0	3.00
4.00	CLINICAL SOCIAL WORKER	31.00	2,206		0.00	0	4.00
5.00	OTHER ALLIED HEALTH PERSONNEL	36.00	15,158		0.00	0	5.00
100.00	**GRAND TOTALS**		**135,883**			**135,883**	100.00

(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.

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CALCULATION OF FEDERALLY QUALIFIED HEALTH CENTER COSTS

Worksheet B
Parts I & II

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

	Position	From Wkst. A, col. 7, line:	Direct Cost by Practitioner from Wkst. A	Total Medical & Mental Health Visits by Practitioner	Other Direct Care Costs (see instructions)	General Service Cost (see instructions)	Total Costs by Practitioner	Average Cost Per Visit by Practitioner	Total Visits Medical Visits by Practitioner	
		0	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	PHYSICIAN	23.00	135,853	113	8,043	111,804	**255,700**	2,262.83	113	1.00
2.00	PHYSICIAN SERVICES UNDER AGREEMENT	24.00	0	0	0	0	**0**	0.00	0	2.00
3.00	PHYSICIAN ASSISTANT	25.00	0	0	0	0	**0**	0.00	0	3.00
4.00	NURSE PRACTITIONER	26.00	170,958	942	67,045	184,922	**422,925**	448.96	695	4.00
5.00	VISITING REGISTERED NURSE	27.00	0	0	0	0	**0**	0.00	0	5.00
6.00	VISITING LICENSED PRACTICAL NURSE	28.00	0	0	0	0	**0**	0.00	0	6.00
7.00	CERTIFIED NURSE MIDWIFE	29.00	0	0	0	0	**0**	0.00	0	7.00
8.00	CLINICAL PSYCHOLOGIST	30.00	0	0	0	0	**0**	0.00	0	8.00
9.00	CLINICAL SOCIAL WORKER	31.00	8,461	76	5,409	10,777	**24,647**	324.30	0	9.00
10.00	REG DIETICIAN/CERT DSMT/MNT EDUCATOR	33.00	0	0	0	0	**0**	0.00	0	10.00
11.00	TOTALS		**315,272**	**1,131**	**80,497**	**307,503**	**703,272**		**808**	11.00
12.00	UNIT COST MULTIPLIER				71.173298	0.776976				12.00
13.00	TOTAL COST PER VISIT							**621.81**		13.00

	Position	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	
		8.00	9.00	10.00	11.00	12.00	
1.00	PHYSICIAN	0	0	0	0	0	1.00
2.00	PHYSICIAN SERVICES UNDER AGREEMENT	0	0	0	0	0	2.00
3.00	PHYSICIAN ASSISTANT	0	0	0	0	0	3.00
4.00	NURSE PRACTITIONER	247	212	42	95,180	18,856	4.00
5.00	VISITING REGISTERED NURSE	0	0	0	0	0	5.00
6.00	VISITING LICENSED PRACTICAL NURSE	0	0	0	0	0	6.00
7.00	CERTIFIED NURSE MIDWIFE	0	0	0	0	0	7.00
8.00	CLINICAL PSYCHOLOGIST	0	0	0	0	0	8.00
9.00	CLINICAL SOCIAL WORKER	76	0	29	0	9,405	9.00
10.00	REG DIETICIAN/CERT DSMT/MNT EDUCATOR	0	0	0	0	0	10.00
11.00	TOTALS	**323**	**212**	**71**	**95,180**	**28,261**	11.00
12.00	UNIT COST MULTIPLIER						12.00
13.00	TOTAL COST PER VISIT				**448.96**	**398.04**	13.00

PART II - CALCULATION OF ALLOWABLE DIRECT GRADUATE MEDICAL EDUCATION COSTS

		Total Cost (from Wkst. A col. 7, line 47)	Total Visits	Title XVIII Visits	Ratio of Title XVIII Visits to Total Visits	Allowable Title XVIII Direct GME Costs	
		1.00	2.00	3.00	4.00	5.00	
14.00	ALLOWABLE GME COSTS	0	1,131	283	0.250221	0	14.00

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COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST **Worksheet B-1**

		PNEUMOCOCCAL VACCINES	INFLUENZA VACCINES	COVID-19 VACCINES	MONOCLONAL ANTIBODY PRODUCTS	
		1.00	2.00	2.01	2.02	
1.00	Health care staff cost (from Worksheet A, column 7, sum of lines 23, and 25 through 36)	373,414	373,414	373,414	373,414	1.00
2.00	Ratio of staff time to total health care staff time	0.000000	0.000000	0.000000	0.000000	2.00
3.00	Total health care staff cost (line 1 x line 2)	0	0	0	0	3.00
4.00	Injections/Infusions and related medical supplies cost (from Worksheet A, column 7, lines 48, 49, 49.10, and 49.11, respectively)	0	0	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 + line 4)	0	0	0	0	5.00
6.00	Total cost of the FQHC (from Worksheet A, column 7, line 100, minus Worksheet A, column 7, line 8)	422,066	422,066	422,066	422,066	6.00
7.00	Total administrative overhead (from Worksheet A, column 7, line 8)	281,206	281,206	281,206	281,206	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 / line 6)	0.000000	0.000000	0.000000	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	0	0	0	9.00
10.00	Total cost of injections/infusions and their administration (sum of lines 5 and 9)	**0**	**0**	**0**	**0**	10.00
11.00	Total number of injections/infusions (from your records)	0	0	0	0	11.00
12.00	Cost per injections/infusions (line 10 / line 11)	0.00	0.00	0.00	0.00	12.00
13.00	Number of injections/infusions administered to Original Medicare beneficiaries	0	0	0	0	13.00
13.01	Number of COVID-19 injections/infusions administered to MA enrollees			0	0	13.01
14.00	Cost of injections/infusions and their administration costs furnished to Medicare beneficiaries (line 12 times the sum of lines 13 and 13.01, as applicable)	0	0	0	0	14.00
15.00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01 and 2.02, line 10)	**0**				15.00
16.00	Total Medicare cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01 and 2.02, line 14) (transfer this amount to Worksheet E, line 3)	**0**				16.00

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CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E

		1.00	
1.00	FQHC PPS Amount	33,311	1.00
2.00	Direct graduate medical education payments (from Worksheet B, Part II, line 14, column 5)	0	2.00
3.00	Medicare cost of vaccines and their administration (From Worksheet B-1, line 16)	0	3.00
4.00	Medicare advantage supplemental payments (for information only)	0	4.00
5.00	Total (sum of amounts on lines 1 through 3)	**33,311**	5.00
6.00	Primary payer payments	0	6.00
7.00	Total amount payable for program beneficiaries (line 5 minus line 6)	**33,311**	7.00
8.00	Coinsurance billed to program beneficiaries	6,662	8.00
9.00	Net Medicare reimbursement excluding bad debts (line 7 minus line 8)	26,649	9.00
10.00	Allowable bad debts (see instructions)	0	10.00
11.00	Adjusted reimbursable bad debts (see instructions)	0	11.00
12.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	12.00
13.00	Subtotal (line 9 plus line 11)	**26,649**	13.00
13.50	Demonstration payment adjustment amount before sequestration	0	13.50
14.00	OTHER ADJUSTMENTS (SPECIFY) (SEE INSTRUCTIONS)	0	14.00
15.00	Amount due FQHC prior to the sequestration adjustment (see instructions)	26,649	15.00
16.00	Sequestration adjustment (see instructions)	0	16.00
16.25	Sequestration for non-claims based amounts (see instructions)	0	16.25
16.50	Demonstration payment adjustment amount after sequestration	0	16.50
17.00	Amount due FQHC after sequestration adjustment (see instructions)	26,649	17.00
18.00	Interim payments	26,649	18.00
19.00	Tentative settlement (for contractor use only)	0	19.00
20.00	Balance due FQHC/program (line 17 minus lines 18 and 19)	**0**	20.00
21.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	21.00

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ANALYSIS OF PAYMENTS TO THE FEDERALLY QUALIFIED HEALTH CENTER FOR SERVICES RENDERED

Worksheet E-1

		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to FQHC		26,649	1.00
2.00	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		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98))		**0**	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E, line 18)		**26,649**	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		**26,649**	7.00

		Name of Contractor	Contractor Number	NPR Date (mm/dd/yyyy)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

(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.

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STATEMENT OF REVENUE AND EXPENSES **Worksheet F-1**

		Title XVIII Medicare	Title XIX Medicaid	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Gross patient revenues	108,033	394,822	104,171	**607,026**	1.00
				1.00	2.00	
2.00	Less: Allowances and discounts on patients' accounts				93,136	2.00
3.00	Net patient revenues (Line 1 minus line 2)				513,890	3.00
4.00	Operating expenses (From Worksheet A, column 3, line 100)				703,272	4.00
5.00	Additions to operating expenses (Specify)			0		5.00
6.00				0		6.00
7.00				0		7.00
8.00				0		8.00
9.00				0		9.00
10.00	Total additions (sum of lines 5 through 9)				**0**	10.00
11.00	Subtractions from operating expenses (specify)			0		11.00
12.00				0		12.00
13.00				0		13.00
14.00				0		14.00
15.00				0		15.00
16.00	Total subtractions (sum of lines 11 through 15)				**0**	16.00
17.00	Total operating expenses (sum of line 4, plus line 10, minus line 16)				**703,272**	17.00
18.00	Net income from service to patients (Line 3 minus line 17)				**-189,382**	18.00
Other income:						
19.00	Contributions, donations, bequests, etc.			0		19.00
20.00	Income from investments			0		20.00
21.00	Purchase discounts			0		21.00
22.00	Rebates and refunds of expenses			0		22.00
23.00	Sale of Medical and Nursing Supplies to other than patients			0		23.00
24.00	Sale of durable medical equipment to other than patients			0		24.00
25.00	Sale of drugs to other than patients			0		25.00
26.00	Sale of medical records and abstracts			0		26.00
27.00	Government Appropriations			0		27.00
28.00	Other revenues (Specify)			0		28.00
28.50	COVID-19 PHE Funding			0		28.50
29.00				0		29.00
30.00				0		30.00
31.00				0		31.00
32.00	Total Other Income (Sum of lines 19 through 31)				**0**	32.00
33.00	Net Income or Loss for the period (Line 18 plus line 32)				**-189,382**	33.00