

**INSTRUCTIONS
MEDI-CAL COST REPORT
RATE SETTING/FREESTANDING
FEDERALLY QUALIFIED HEALTH CENTER (FQHC)
RURAL HEALTH CLINIC (RHC)
PROSPECTIVE PAYMENT SYSTEM (PPS)**

Please read all instructions carefully before completing these forms.

These instructions assist the provider in preparing the FQHC/RHC Medi-Cal Rate Setting Cost Report in conformance with the State Medi-Cal cost reporting requirements. All costs claimed are subject to the Medicare cost reimbursement principles in Title 42 Code of Federal Regulations (CFR), Part 413, California's State Medi-Cal Plan, and current Financial Audits Branch policies.

FILING A COST REPORT

All Medi-Cal providers follow the e-File Medi-Cal Worksheets Submission Protocol for submission of FQHC/RHC Worksheets. Submit the e-file worksheets to the inbox below and include the audited financial statements (if applicable), trial balance, and working papers used to prepare the Worksheets. You will receive an email response.

- Ratesetting.Clinics@dhcs.ca.gov

Documents must be complete. Worksheets will be returned if not completed in accordance with these instructions.

For assistance/questions, please contact the FQHC/RHC Section at (916) 322-1681 or Clinics@dhcs.ca.gov.

COVER SHEET

This Worksheet will automatically populate based on the information entered on the Certification Sheet.

CERTIFICATION SHEET—GENERAL INFORMATION AND CERTIFICATION

The individual signing this statement must be an officer or other authorized representative. A DocuSign Certification Statement located on the [DHCS](#) Forms & Publications webpage is required. The cost report will be returned if a Certification Statement does not accompany it.

Select from the drop-down menu to indicate if the cost report is based on projected costs for the purpose of setting an interim rate or reporting actual costs for the first full year of operation for the purpose of setting a final PPS rate. Attach additional sheets as necessary.

PART A—GENERAL INFORMATION

1. Enter FQHC/RHC Name
2. Enter the Type of Report (Select from drop-down menu)
3. Enter Date Submitted (mm/dd/yyyy)
4. Enter FQHC/RHC Street Address
5. Enter City
6. Enter State and Zip Code
7. Enter Cost Report Preparers Name
8. Enter Cost Report Preparers Title
9. Enter Cost Report Preparers Phone Number (xxx) xxx-xxxx
10. Enter Cost Report Preparers E-mail
11. Enter Clinic Type (Select from drop-down menu)
12. Enter Date of Qualification (mm/dd/yyyy)
13. Enter NPI Number
14. Enter Reporting Period Begin (mm/dd/yyyy)
15. Enter Reporting Period End (mm/dd/yyyy)
16. Enter Type of Control (Select from drop-down menu)
17. Enter Type of Organization (Select from drop-down menu)
18. Enter Other (Specify Type)

Owners of Facility and Percentage Owned

19. Enter Provider Name
20. Enter Address/Location
21. Enter NPI Number

PART A1—Related Parties and Organizations Disclosure

22. Enter Provider Name
23. Enter Address/Location
24. Enter NPI

Names of Physicians

25. Enter Physician Name
26. Enter Billing/NPI Number

Statement of Compensation

27. Enter Name of Owner/Relatives
28. Enter Title
29. Enter Percentage of Ownership Interest
30. Enter Average Hours Worked per Week (Indicate name in parentheses) ()
31. Enter Compensation Included in Cost Report

PART B—CERTIFICATION BY OFFICER OF THE HOME OFFICE

Refer to the Certification Statement located on the [DHCS](#) Forms & Publications webpage for all FQHC/RHC Home Office Cost Reports submitted. We will reject any cost report filed without a completed DocuSign certification statement. The individual E-signing this statement must be an officer or other authorized person.

Read the certification statement carefully, and either the administrator, controller, corporate officer, or member of the board of directors must sign it. The official signing the report must have the legal capacity to make commitments for the organization.

WORKSHEETS 1, 1A, & 1B—TRIAL BALANCE OF EXPENSES—RECLASSIFICATION & ADJUSTMENT

Worksheet 1, Columns 1 and 2 are used to record the trial balance of expenses from the clinic's accounting books and records. The cost report must reconcile to the provider's general ledger and the audited financial statements. **Round all amounts to the nearest dollar. Attach additional sheets if necessary.**

Enter in Column 4 any reclassifications needed for proper cost allocation. For example, if a physician's duties include some administrative duties, the appropriate portion of compensation and applicable payroll taxes and fringe benefits may be reclassified from Line 1 to Line 42, Office Salaries. All reclassifications in Column 4 must be detailed on Worksheet 1A. Worksheet 1A provides an explanation of the reclassifications and indicates the amount allocated to each of the affected cost centers. The net total of Column 4 must equal zero.

Enter in Column 6 any adjustments to the reclassified expenses. Adjustments are required for **home office costs** and to adjust expenses in accordance with allowable costs as defined in 42 CFR, Part 413. All adjustments in Column 6 must be detailed on Worksheet 1B. Worksheet 1B provides a description of the adjustment, the basis of adjustment (cost or amount received), dollar amount, and the affected cost center(s). Reductions to expenses are shown in brackets.

(Transferred Home Office costs must agree with the amounts from DHCS 3089 or 3089.1 Home Office Cost Report—Schedule 6)

WORKSHEET 2: PARTS A & B—DETERMINATION OF FQHC/RHC COSTS AND RATE PER VISIT

This Worksheet is used to determine the total costs of health care services and to determine the PPS reimbursement rate. The numbers used in this Worksheet flow from other Worksheets. Once all of the Worksheets are completed, this schedule will be automatically calculated due to formulas contained in the Worksheet.

Part A—Determination of Overhead Applicable to FQHC/RHC Services (Lines 1 through 8)

The purpose of this section is to allocate overhead costs (capital and administrative) reported on Worksheet 1, Page 2, Line 55 to the FQHC/RHC Health Care Services Costs and Nonreimbursable Cost centers. Costs are allocated based to each component based on a percentage of total costs (excluding overhead).

Part B—Determination of FQHC/RHC Rate Per Visit (Lines 1 through 5)

The purpose of this section is to determine the FQHC/RHC PPS rate per visit payable by the Medi-Cal program. The PPS rate is computed by dividing the total reimbursable costs computed in PART A by total reimbursable visits from Worksheet 6 per the provider's records. Total visits include

all visits for all payor types meeting the definition of a "visit" as outlined below REGARDLESS of whether such visits were billed and/or paid. The same definition for patient visits must be used for both billing and rate-setting purposes.

A "visit" for purposes of reimbursing FQHC/RHC services is based on the following:

A face-to-face encounter between an FQHC or RHC patient and a physician, a resident in a Teaching Health Center Graduate Medical Education Program under supervision of teaching physician (effective 04/01/2018), physician assistant, nurse practitioner, acupuncturist, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, hereafter referred to as a "health professional," to the extent the services are reimbursable as covered benefits described in section 1905(a)(2)(C) of the Social Security Act (the Act) that are furnished by an FQHC or services described in section 1905(a)(2)(B) of the Act that are furnished by an RHC.

The definition of "physician" includes the following:

- a. A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license.
- b. A doctor of podiatry is authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license.
- c. A doctor of optometry is authorized to practice optometry by the State and who is acting within the scope of his/her license.
- d. A doctor authorized to administer chiropractic services by the State and who is acting within the scope of his/her license.
- e. A doctor of dental surgery (dentist) is authorized to practice dentistry by the State and who is acting within the scope of his/her license.

Inclusion of a professional category within the term "physician" is for the purpose of defining the professionals whose services are reimbursable on a per-visit basis, and not for the purpose of defining the types of services that these professionals may render during a visit (subject to the appropriate license).

Comprehensive perinatal services when provided by a comprehensive perinatal services practitioner as defined in the California Code of Regulations, Title 22, Section 51179.7.

Encounters with more than one health professional and multiple encounters with the same health professional, which take place on the same day and at a single location, constitute a single visit. More than one visit may be counted on the same day (which may be at a different location) in either of the following situations:

- a. When the clinic patient, after the first visit, suffers illness or injury requiring another diagnosis or treatment, then two visits may be counted.
- b. The clinic patient is seen by a dentist or registered dental hygienist and sees any one of the following providers: physician (as defined above in PART B (a)(i)-(v)), physician assistant, nurse practitioner, certified nurse-midwife, clinical psychologist, licensed clinical social worker, visiting nurse, or comprehensive perinatal services, practitioner.

Line 1: Reimbursable FQHC/RHC costs (Part A, line 8)

Line 2: Total FQHC/RHC visits (as defined above) from Worksheet 6, column 5, line 20.

Line 3: FQHC/RHC PPS rate per visit (Part B, line 1 divided by Part B, line 2)

WORKSHEET 3—VISITS, REVENUES, AND EXPENDITURES

Total Visits: Enter the total number of visits recorded by the funding source. Please include all programs and visit statistics specific to your organization.

Note: Total visits reported in Column 1 must agree with total visits reported on Worksheet 6, Column 2, and line 20.

Related Revenues: Enter the total revenue received by the funding source. Enter all categories for which revenues are received for patient services provided even when the services do not constitute a "visit," such as grant/contract funding received for outreach programs. The "Other" category may also include any non-patient revenues.

Note: Total revenues reported in Column 2 must agree with the total patient and non-patient revenues recorded in the clinic's general ledger or reported in the independently audited financial statements if completed at the time of filing the cost report.

Related Expenditures: Enter the expenditures recorded by the funding source with the exception of lines 1 through 12.

WORKSHEET 4—SUMMARY OF SERVICES PROVIDED BY CLINIC

List all services available at, or provided by, the clinic. Identify any provider's contractor name and location.

Place an "X" in the "NO" column if the service is not available or provided by the clinic.

Place an "X" in the "ON-SITE" column if the service is provided on-site by the clinic.

Place an "X" in the "OFF-SITE" column if the service is provided off-site under a contractual arrangement. Please provide the contractor's name.

WORKSHEET 5—SUMMARY PRODUCTIVE FTEs AND VISITS OF HEALTHCARE PRACTITIONERS

Column 1—FTE's: Record the total number of healthcare practitioner positions by Full-Time Equivalent (FTE) using 2,080 hours as the standard. Calculate for each person in each category their ANNUAL PRODUCTIVE time worked. Only include time performing essential functions related to patient care. Do not include time performing chart reviews/consultations, supervising others, or administrative duties. Never include time off for sick, vacation, or holidays. Divide the annual productive time by 2,080 to determine the percentage of time each person is actively engaged in patient care activities. For example, if a physician spent 1,040 hours seeing patients, the FTE would be calculated as $(1,040/2,080 = .5$ FTEs). Compile the FTE's by category. Do not include mental health staff in the minimum standards assessment.

Column 2—# of VISITS: Record the total visits (as previously defined) furnished to all patients for each of the applicable health care staff categories.

Columns 3 & 4—ON-SITE/OFF-SITE: Place an "X" in the column "ON-SITE" or "OFF-SITE" to identify where the staff is located.

WORKSHEET 6—PRODUCTIVITY STANDARDS ASSESSMENT

The purpose of this Worksheet is to determine if the provider has met the minimum number of visits standards and to determine the visit count for the PPS rate determination.

Enter the number of FTE's and visits furnished by the healthcare staff as determined on Worksheet 5. Determine if the provider has met the minimum number of visits standard and can therefore use actual visit counts for its PPS rate determination.

Productivity standards are used to help determine the average cost per patient for Medi-Cal reimbursement in the RHC or FQHC. The current productivity standards require 4,200 visits per full-time equivalent physician or contracted physician on an ongoing basis and 2,100 visits per full-time equivalent non-physician practitioner or contracted on an ongoing basis (NP, PA, or CNM). Physician and non-physician practitioner productivity may be combined for staff with the same productivity standards. The FTE on the cost report for providers is the time spent seeing patients or scheduled to see patients, net of all time spent in non-patient care activities, including administrative duties.

This Worksheet will automatically calculate the visits based on the information entered from Worksheet 5 and apply the productivity standards.

Columns 1 & 2—Summarizes the number of FTE's and visits furnished by the health care staff from Worksheet 5.

Column 3—The productivity standards, are screening guidelines to determine reasonable service levels furnished by certain healthcare staff. Payments for services are subject to these guidelines used to test the reasonableness of the productivity of the clinic/center's health care staff. These guidelines are applied to staff for FQHC/RHC services furnished both at the clinic/center's site and in other locations.

They are as follows:

- At least 4,200 visits annually per full-time equivalent physician employed by the clinic or contracted on an ongoing basis.
- At least 2,100 visits per year per full-time equivalent physician assistant, nurse practitioner, or certified nurse-midwife employed by the clinic or contracted on an ongoing basis.

Column 4—The minimum visits are computed for Lines 1 through 5 by multiplying FTEs in Column 1 by productivity standards in Column 3. These are minimum visits that personnel is expected to furnish cumulatively.

Column 5—Lines 1 through 5 are evaluated for minimum productivity standards per CMS guidelines. On Line 6, Column 5, the actual visits on Column 2, Line 6 are compared to the minimum visits on Column 4, Line 6. The greater of the two is used as the visit number on Column 5, Line 6.

For lines 7 through 19, the actual number of visits is carried forward to Column 5 from Column 2.

The reimbursable visits from Lines 7 through 19 are summed on Column 5, Line 20 and carried to Worksheet 2, Part B, Line 2 to calculate the PPS rate per visit

The total visits on Column 5, Line 22 are the sum of reimbursable visits on Line 20 and the nonbillable/nonreimbursable visits on Line 21 and should match with total visits on Worksheet 5.