

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	PROVIDER CCN: _____ COMPONENT CCN: _____	PERIOD: FROM _____ TO _____	WORKSHEET M-5
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Check applicable box: Hospital-based RHC Hospital-based FQHC

DESCRIPTION	Part B			
	1	2		
	mm/did/ivy	Amount		
1 Total interim payments paid to hospital-based RHC/FQHC			1	
2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting periods. If none, write "NONE", or enter zero.			2	
3 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 zero ⁽¹⁾ . Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	Program to	.01		3.01
		.02		3.02
	Provider	.03		3.03
		.04		3.04
		.05		3.05
	Provider to	.50		3.50
		.51		3.51
	Program	.52		3.52
		.53		3.53
		.54		3.54
	.99		3.99	
4 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)			4	

TO BE COMPLETED BY CONTRACTOR

5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE," or enter zero (1). Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	Program to	.01		5.01
		.02		5.02
	Provider	.03		5.03
		.50		5.50
	Provider to	.51		5.51
		.52		5.52
	.99		5.99	
6 Determine net settlement amount (balance due) based on the cost report (see instructions). (1)	Program to			
		Provider	.01	6.01
	Provider to			
	Program	.02		6.02
7 Total Medicare liability (see instructions)				7
8 Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)		8

⁽¹⁾ On lines 3, 5, and 6, where an amount is due component to program, show the amount and date on which you agree to the amount of repayment, even though the total repayment is not accomplished until a later date.