WISCONSIN MEDICAID
COST REPORT FOR PROVIDER-BASED RURAL HEALTH CLINICS INSTRUCTIONS

Wisconsin Medicaid requires certain information to enable the programs to certify providers and to authorize and pay for medical services provided to eligible members. Although these form instructions refer to Wisconsin Medicaid, this form also applies to BadgerCare Plus.

Personally identifiable information about providers is used for purposes directly related to Medicaid administration, such as determining the certification of providers or processing provider claims for reimbursement. Non-submission of cost report data will result in no settlement determination being made.

The use of this form is voluntary, but providers are required to submit the information required on the form for a settlement determination and payment to take place.

This form is to record operating costs incurred by the rural health clinic (RHC). These costs are from the trial balance of the RHC's financial records and Medicare cost reports. Overhead assigned from the Medicare Cost Report, CMS Form 2552-96, Worksheet B, Part I, must be broken out into separate categories per the designated line items. All expenses/costs will need to be listed, including those that are not direct RHC services.

Wisconsin Medicaid does not consider diagnostic services, such as laboratory or radiology, as directly related RHC expenses. They are appropriately classified as non-RHC costs. This also includes pharmaceutical costs.

Cafeteria, dietary, and advertising costs are considered non-reimbursable RHC costs. These costs should be included as non-RHC costs since they are part of the overall RHC operations and will be used to determine the proportional overhead expenses that are directly related to RHC primary care operations. Overhead will need to meet the criteria of reasonableness for encounter rate calculations.

Adjustments and reclassifications to clinic trial expenses should appropriately reflect the costs incurred at the RHC. Supporting schedules, such as Bridge worksheets, for the adjustments and reclassifications should be submitted with the cost report. It is also recommended that the provider submit a copy of the clinic's trial balance and filed Medicare Cost Report to the Office of the Inspector General (OIG). If these files are not submitted directly to OIG, they will need to be available for review by the OIG RHC auditor at the time of the settlement determination.

SECTION I – PROVIDER INFORMATION

This section requires the following information from the provider:

- RHC provider's National Provider Identifier (NPI) and Medicaid provider numbers
- Date span of the reporting period

SECTION II – FACILITY HEALTH CARE STAFF COSTS

The actual salaries and benefits attributable to the RHC primary care staff (physicians, physician assistants, pharmacists, nurse practitioners, and nurse midwives) should be listed in this section.

SECTION III – OTHER DIRECT RHC HEALTH CARE COSTS

The expenses directly related to primary care services rendered at the RHC should be listed. This includes medical records, staff salaries, and medical equipment cost and depreciation.

SECTION IV – FACILITY OVERHEAD

The expenses related to clinic operations that are not directly associated with patient care services should be listed. Medicare Cost Report overhead expenses will need to be separated out and appropriately classified into the Cost Report for Provider-Based Rural Health Clinics form, F-11023. Any cafeteria costs allocated via the Medicare Cost Report should be appropriately classified into the non-RHC costs section. Overhead will also need to meet the criteria of reasonableness.

SECTION V – NON-RHC COSTS

These are expenses incurred by the RHC in its operations that are not related to primary care services. All incurred laboratory, radiology, advertising, cafeteria, dietary, and pharmacy costs should be listed in this section and not excluded or zeroed out.