1. Status:	As Filed (Provider Version) --	X	Desk Reviewed --		
	Revised Desk Reviewed --		Field Audited --		
	Medicaid Reimbursement Status				
	Cost Settled (APM)		PPS		

NORTH CAROLINA DIVISION OF HEALTH BENEFITS
2018 FEDERALLY QUALIFIED HEALTH CENTER COST REPORT

2. Name and Address					
Name of Facility:					
Street or P.O. Box:					
City:		State:		Zip:	
County:		Telephone No:			
3. Cost Reporting Period	From:		To:		

4. NPI Provider No.:	Medicaid Provider No.:	NPI Provider No.:	Medicaid Provider No.:

5. Type of Control	a. Voluntary Nonprofit		b. Proprietary	
	1. Corporation		3. Individual	
	2. Other (Specify)		4. Corporation	
			5. Partnership	
			6. Other (Specify)	
	c. Government			
	7. Federal		10. State	
	8. City/County		11. City	
	9. County		12. Other (Specify)	

6. If we have questions regarding the cost report, who should we contact?				7. If the Notice of Program Reimbursement Settlement should be mailed to other than the facility, please list the name and address.			
Name:							
Address:				Name:			
City:				Address:			
State:		Zip:		City:			
Contact Name:				State:		Zip:	
Telephone:							
E-Mail:							

INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY that I have read the above statement and examined the accompanying schedules prepared by _____ for the cost report period beginning _____
(Name of Facility)
and ending _____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the facility in accordance with applicable instructions, except as noted.

Signature _____
(Officer or Administrator)

Title _____

Date _____