

RURAL HEALTH CLINICS
DIVISION OF HEALTH BENEFITS
MEDICAID COST REPORTING SCHEDULES
2018
INSTRUCTIONS

Effective for 2015 cost report year, the Medicaid schedules for the Medicaid Cost Report and Medicaid PPS Reconciliation have been combined. The instructions identify if specific schedules apply only to Cost Settled Providers or PPS Providers.

Per the North Carolina State Plan, Attachment 4.19-B, Section 2 for RHC providers:

Providers who elected to be reimbursed in accordance to the cost-based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005 shall remain with that choice of cost-based reimbursement methodology. (Cost Settled Provider)

Effective for 2018 cost report year, North Carolina Health Choice reconciliation schedules have been added to the Medicaid cost report (DHB-5A & 9A).



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Health Benefits

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
DAVE RICHARD • Deputy Secretary, NC Medicaid

November 1, 2018

Dear RHC Provider:

In accordance with the Medicaid Participation Agreement Paragraphs 6 and 7, RHC providers are required to file an annual year ending cost report with the Division of Health Benefits. Providers can access the cost reporting forms and instructions on-line at <https://medicaid.ncdhhs.gov/providers/cost-reports-and-assessments/rural-health-clinicsfederally-qualified-health-centers-cost> and select the appropriate cost report.

Your cost report is due by the end of the fifth month of the year ending service period. The following information **must** be submitted **along with your original Medicaid RHC cost report**:

- A full copy of your facility's signed and certified Medicare cost report (CMS 222-17).
- A copy of your facility's "crosswalk" working trial balance with sufficient detail to support the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicaid report.
- Defined chart of accounts.
- Log of bad debts, if applicable.
- Log of pneumococcal and influenza vaccines administered to Medicaid beneficiaries above eighteen years old included on DHB-7. This log must include each beneficiary's Medicaid ID number and birthdate.
- Financial Statements, audited or unaudited, at time of submission.
- List of all State and Federal grant revenues including the title of the grant and amount of revenues for the reporting period.

Please submit the above-referenced cost report and information to:

US Mail

**Audit Section
Attn: Joy Liu
Division of Health Benefits
2501 Mail Service Center
Raleigh, NC 27699-2501**

Express Mail/Shipping

**Audit Section
Attn: Joy Liu
Division of Health Benefits
333 East Six Forks Road, Suite 200
Raleigh, NC 27609**

If a settlement is due the Medicaid program, make check payable to *Division of Health Benefits* for the amount due and remit it under separate cover to:

**DHHS Controller's Office
Accounts Receivable – Health Benefits
2022 Mail Service Center
Raleigh, NC 27699-2022**

If you have questions, please contact Joy Liu at (919) 814-0022 or email Joy.Liu@dhhs.nc.gov

Sincerely,

Jim Flowers
Associate Director of Provider Audit

**NC MEDICAID
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS**

LOCATION: 333 E. Six Forks Road, Raleigh NC 27609
MAILING ADDRESS: 2501 Mail Service Center, Raleigh NC 27699-2001
www.ncdhhs.gov • TEL: 919-814-0060 • FAX: 919-814-0037

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DHB RHC MEDICAID SCHEDULES INSTRUCTIONS

RECOMMENDED SEQUENCE FOR COMPLETING MEDICAID SCHEDULES

The Medicaid Schedules are to be completed after the Medicare Cost Reporting Worksheets (FORM CMS-222-17) are completed.

<u>Step Number</u>	<u>Schedule</u>	<u>Cost Report Page</u>	<u>Instructions</u>
1	Facesheet	1	Page 2. Complete Sections 1 – 7.
2	DHB - 1	2	Page 3. Complete Schedule.
3	DHB - 2	3	Pages 4 - 5. Complete Schedule.
4	DHB - 3	4	Pages 6 - 7. Complete Schedule.
5	DHB - 4	5	Page 8 - 9. Complete Lines 1 - 5.
6	DHB - 5	6	Page 10. Complete Schedule.
7	DHB - 6	8	Page 11. Complete Schedule.
8	DHB - 7	9	Page 11. Complete Schedule.
9	DHB - 4	5	Page 8 - 9. Complete Lines 6 - 11.
10	DHB - 8	10	Page 12. Cost-Settled Providers ONLY Complete Schedule.
11	DHB – 9	11	Page 13 PPS Reconciled Providers ONLY Complete Schedule.
12	DHB-5A	7	Page 14 Complete Schedule
13	DHB-9A	12	Page 15. Complete Schedule
14	Facesheet	1	Pages 2 & 15. Complete Certification Statement.
15	Cost Report Checklist		Page 16. Ensure documents on the list are submitted to DHB.

DHB RHC MEDICAID SCHEDULES INSTRUCTIONS

DHB-SCHEDULES

GENERAL INFORMATION AND CERTIFICATION - PAGE 1 (Cost Settled and PPS)

Warning: If you downloaded the Excel spreadsheet and are keying data into a worksheet, please remember you need only key data into the **lightly shaded cells**. Each worksheet contains formulas that process data only from the shaded cells and will not work correctly if you make entries in unshaded fields.

Note: Please follow the recommended sequence for completing your cost report schedules to assure the data flows correctly for all schedules.

1. Check appropriate box identifying the provider's Medicaid Reimbursement Status.
 - a. Providers must select PPS unless they are a provider who elected to be reimbursed in accordance to the cost-based methodology in effect on December 31, 2000, and who did not change their election prior to January 1, 2005; they shall remain with that choice of cost-based reimbursement methodology. (Cost Settled Provider)
2. Enter name, address, county and telephone number.
3. Enter cost reporting period. This period must coincide with the Medicare Cost Report.
4. Enter all NPI numbers (and Medicaid provider numbers) assigned to facility. If additional space is needed, attach a separate sheet with the additional NPI and Medicaid provider numbers. If no Medicaid Provider Number was assigned after 7/1/2013, enter only the NPI.
5. Check appropriate box identifying type of control.
6. Enter the individual we should contact to answer questions about the cost report schedules, including the person's email address.
7. Enter the address we should mail all Medicaid settlements if different from the address of the facility in Item 1.

Certification Statement

Enter the full name of the facility and reporting period covered by the report.

Statement must be signed by officer or administrator of the facility **after** all schedules have been completed. The statement filed **must** have an original signature.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

COST OF MEDICAID CORE SERVICES - PAGE 2 / DHB-1 (Cost Settled and PPS)

The purpose of this schedule is to compute Medicaid Core Cost based on the Medicare Cost Report and Medicaid visits from the provider records.

Columns 1 and 2 must be completed if the rate for Medicare Covered Visits is different between 2017 (Column 1) and 2018 (Column 2). Column 3 is total of Columns 1 and 2. Column 1 should be completed based on visits furnished during 2017. Column 2 should be completed based on visits furnished during 2018. If rate is the **same** for both periods, you may complete Column 2 covering the entire cost reporting period.

The rate is the Medicare settlement rate.

Line 1

Enter from the Medicare Cost Report, Worksheet C, Part I, Line 9, corresponding columns.

Line 2

Enter Medicaid covered visits for all Core Services (including Mental Health Services) from provider's records.

Line 3

Compute total cost of all Core Services. Multiply Line 1 times Line 2.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

COST OF OTHER AMBULATORY SERVICES - PAGE 3 / DHB-2 (Cost Settled and PPS)

The purpose of this schedule is to identify the cost of Ambulatory Services based on the Medicare Cost Report and compute overhead cost applicable to allowable Medicaid Ambulatory Services.

Line 1

Enter Cost of Other RHC Services excluding overhead from Medicare Cost Report, Worksheet A, Column 7, Line 86 less any cost for Health Check Coordinator. This amount **must** agree with the total of Lines 1a – 1h.

Identify the cost of the Ambulatory Services furnished by the facility. Each facility determines which Ambulatory Services it will furnish.

Line 1a

Worksheet A, Column 7, Line 75 of the Medicare Cost Report.

Line 1b

Worksheet A, Column 7, Line 76 of the Medicare Cost Report.

Line 1c

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Health Check (formerly EPSDT) Services (*Compensation and fringe benefits of Physician, Nurse Practitioner, or Physician's Assistant and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 77-81.

Line 1d

Worksheet A, Column 7 of the Medicare Cost Report. Cost of on-site Radiology Services identified by the facility which would be included on Worksheet A, Column 7, Lines 77-81.

Line 1e

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Norplant Services (*Compensation and fringe benefits of Physicians) identified by the facility which would be included on Worksheet A, Column 7, Lines 77-81.

Line 1f

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Physician Hospital Services (*Compensation and fringe benefits of Physician and Professional Liability Insurance) identified by the facility which would be included on Worksheet A, Column 7, Lines 77-81.

Line 1g

No entry required on this line. Enter total cost of Health Check Coordinator on schedule DHB- 4, Line 1g, Column 4.

Line 1h

Worksheet A, Column 7 of the Medicare Cost Report. Cost of Other Medicaid covered services identified by the facility which would be included on Worksheet A, Column 7, Lines 77-81.

***This is not an all-inclusive identification of costs which may be applicable to this service.**

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 3 / DHB-2 continued

Line 2

Enter cost of all services excluding overhead from Medicare Cost Report, Worksheet B, Line 14.

Line 3

Enter percentage of Other RHC Services. Divide Line 1 by Line 2.

Line 4

Enter Net Facility Overhead from Medicare Cost Report, Worksheet B, Line 16.

Line 5

Compute Overhead applicable to Other RHC Services. Multiply Line 3 times Line 4. Transfer amount to Schedule DHB-3, Column 2, Line 3.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

ALLOCATION OF OVERHEAD COST - PAGE 4 / DHB-3 (Cost Settled and PPS)

The purpose of this schedule is to allocate overhead costs to each ambulatory cost center and compute the average cost per encounter or unit of service.

Column 2

Lines 1a – 1h

Transfer costs from Schedule DHB-2 / Page 3 to the corresponding cost center.

Line 2

Total of Lines 1a - 1h.

Line 3

Enter overhead cost from Schedule DHB-2 / Page 3, Line 5.

Line 4

Divide Line 3 by Line 2. Round this amount to the fifth decimal place (0.00000).

Column 3

Line 1a

Multiply Unit Cost Multiplier (Column 2, Line 4) times Pharmacy Cost (Column 2, Line 1a) and enter amount on Line 1a.

Line 1b

Multiply Unit Cost Multiplier (Column 2, Line 4) times Dental Cost (Column 2, Line 1b) and enter amount on Line 1b.

Line 1c

Multiply Unit Cost Multiplier (Column 2, Line 4) times Health Check (formerly EPSDT) Cost (Column 2, Line 1c) and enter amount on Line 1c.

Line 1d

Multiply Unit Cost Multiplier (Column 2, Line 4) times Radiology Services Cost (Column 2, Line 1d) and enter amount on Line 1d.

Line 1e

Multiply Unit Cost Multiplier (Column 2, Line 4) times Norplant Services Cost (Column 2, Line 1e) and enter amount on Line 1e.

Line 1f

Multiply Unit Cost Multiplier (Column 2, Line 4) times Physician Hospital Services Cost (Column 2, Line 1f) and enter amount on Line 1f.

Line 1g

No entry required on this line. Enter total cost of Health Check Coordinator on schedule DHB-4, Line 1g, column 4.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 4 / DHB-3 continued

Line 1h

Multiply Unit Cost Multiplier (Column 2, Line 4) times Other Specified Cost (Column 2, Line 1h) and enter amount on Line 1h.

Line 2

Total of Lines 1a - 1h. Amount **must** agree with Overhead Cost in Column 2, Line 3.

Column 4

Lines 1a - 1h

Total of Columns 2 and 3 for each Line.

Line 2

Total of Columns 2 and 3.

Column 5

Lines 1a - 1h

Total number of encounters / units of service for all consumers served by the provider, including consumers with Medicare, Medicaid, Health Choice, private, self-pay, and insurance.

Number of prescriptions must be used for Pharmacy and encounters / units of service for all other Ambulatory Services.

Column 6

Lines 1a - 1h

Compute the average cost for each Ambulatory Service. Divide Column 4 by Column 5. Transfer amounts to Schedule DHB-4 / Column 2, Lines 1a - 1h.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

**DETERMINATION OF MEDICAID REIMBURSEMENT - PAGE 5 / DHB-4
(Cost Settled and PPS)**

The purpose of this schedule is to compute the Medicaid cost of each Ambulatory Service based on the number of **Medicaid** encounters / units of service, Total Reimbursement Cost (Core and Ambulatory), and Amount Due Provider or Program.

Column 2

Lines 1a - 1h

Transfer costs from Schedule DHB-3 / Page 4 to the corresponding cost center.

Column 3

Lines 1a - 1f, and 1h

Enter total number of **Medicaid** encounters / units of service furnished by the provider for each Ambulatory Service. This information is from the provider's records.

Line 1g

No entry in this block. Enter Total Cost of Health Check Coordinator in Line 1g, Column 4.

Column 4

Lines 1a - 1f, and 1h

Multiply Cost per Encounter (Column 2) times Number of Medicaid Encounters (Column 3).

Line 1g

Enter Total Cost of Health Check Coordinator.

Line 2

Enter Subtotal of Lines 1a - 1h.

Line 3

Enter sum of Medicaid cost for Physician Hospital Services and Health Check Coordinator from Column 4, Lines 1f and 1g.

Line 4

Subtract Line 3 from Line 2.

Line 5

Enter Total Medicaid Core Cost transferred from Schedule DHB-1 / Page 2, Column 3, Line 3.

Line 6

Enter Total Medicaid Cost of Pneumococcal and Seasonal Influenza Vaccine Injections transferred from Schedule DHB-7 / Page 9, Column 3, Line 4.

Line 7

Enter Total of Lines 4, 5, and 6.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PAGE 5 / DHB-4 continued

Line 8

Enter Amount Received / Receivable from Medicaid based on Core and Ambulatory Services furnished to Medicaid beneficiaries. Amount transferred from Schedule DHB-5, Page 6, Column 2, Line 6.

Line 9

Subtract Line 8 from Line 7.

Line 10

Enter Amount of Bad Debts from Schedule DHB-6 / Page 7, Line 5.

Line 11

Compute Amount Due Provider (Program). Add Lines 9 and 10.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

SUMMARY OF MEDICAID PAYMENTS - PAGE 6 / DHB-5 (Cost Settled and PPS)

The purpose of this schedule is to identify Medicaid Received / Receivable amounts and provider numbers for which NC TRACKS rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Carolina Access, Medicaid crossover and Medicaid Pregnancy Medical Home Incentive Payments (S0280 / S0281) are excluded. Co-payments for Ambulatory Services are included.**

Column 2

Lines 1a - 1h

Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2

Enter Received / Receivable amount for Core Services based on the facility's records.

Line 3

Enter Received / Receivable Third Party Liability amount for Ambulatory and Core Services based on the facility's records.

Line 4

Subtotal Lines 1a - 1h, Line 2, and Line 3.

Line 5

Enter Received / Receivable amount for Physician Hospital Services and Health Check Coordinator from Lines 1f and 1g.

Line 6

Compute Total Medicaid Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DHB-4 / Page 5, Column 4, Line 8 and Schedule DHB-8 / Page 10, Line 6.

Column 3

Lines 1a - 1h

Enter NPI numbers used by NC TRACKS to make payments for each Ambulatory Service. Please note, if more space is needed, provider numbers may be listed in the comments section at the bottom of the page.

Line 2

Enter NPI numbers used by NC TRACKS to make payments for Core Services.

Line 3

Enter NPI numbers which Third Party Liability payments were made for Medicaid covered services.

Comments

Use this section as needed. For example, cost reports with multiple providers may list the provider numbers here if column 3, lines 1a-1h, line 2 and line 3 have insufficient space.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

BAD DEBTS - PAGE 8 / DHB-6 (Cost Settled and PPS)

The purpose of this schedule is to compute the amount of Net Bad Debts incurred by the facility.

Line 1

Enter the total co-payment amount billed to Medicaid patients from the facility's records.

Line 2

Enter the co-payment amounts received from Medicaid patients from the facility's records.

Line 3

Compute Medicaid Bad Debts. Subtract Line 2 from Line 1.

Line 4

Enter any recovery of previous Medicaid amounts written off as Bad Debts from the facility's records.

Line 5

Compute Net Bad Debts. Subtract Line 4 from Line 3.

Line 6

Compute the Adjusted Reimbursable Bad Debts. Multiply Line 5 by 65 percent. Transfer to DHB-4, Line 11.

**COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES - PAGE 9 / DHB-7
(Cost Settled and PPS)**

The purpose of this schedule is to compute the Medicaid cost of Pneumococcal and Influenza Vaccine Injections based on the number of injections for Medicaid beneficiaries aged 19 years and older.

Columns 2 and 3

Line 1

Enter cost of Pneumococcal and Influenza Vaccine Injections and its (their) administration in the applicable column from the Medicare Cost Report, Supplemental Worksheet B -1, Line 12.

Line 2

Enter the number of Pneumococcal and Influenza Vaccine Injections administered to Medicaid beneficiaries above eighteen years old in the applicable column. This information is from the provider's records.

NOTE: Do NOT include injections for the following beneficiaries on Line 2:

- Children aged 0 – 18 years who receive vaccines in addition to a Health Check assessment or if vaccine administration is the only service provided on the date of service;
- Children enrolled in the Health Choice program

Line 3

Multiply Cost per Vaccine Injection (Line 1) times number of Medicaid Vaccine Injections (Line 2).

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

Line 4

Enter the Medicaid cost of Pneumococcal and Influenza Vaccine Injections (sum of Columns 2 and 3, Line 3). Transfer this amount to Schedule DHB-4 / Page 5, Column 4, Line 6.

PPS RECONCILIATION SCHEDULE – COST-SETTLED PROVIDERS– PAGE 10 / DHB-8

The purpose of this schedule is to compute PPS payments for cost-settled providers only based on the number of Medicaid Encounters and identify Gross Amount Due Provider or Program.

Lines a - e

Enter total number of **Medicaid** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1

Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2

Enter PPS rate from DHB Rate Setting.

Line 3

Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Total Reimbursable Costs from DHB-4. Sum of Line 7 and Line 10

Line 5

Enter Greater of Line 3 or Line 4.

Line 6

Enter Amount Received from Medicaid from DHB-5, Line 6.

Line 7

Subtract Line 5 from Line 6. If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Health Benefits*** to the address below:

**DHHS Controller's Office
Accounts Receivable - Health Benefits
2022 Mail Service Center
Raleigh, NC 27699-2022**

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

PPS RECONCILIATION SCHEDULE – PPS PROVIDERS– PAGE 11 / DHB-9

The purpose of this schedule is to compute PPS payments for PPS-reconciled providers only based on the number of Medicaid Encounters and identify Gross Amount Due Provider or Program.

NOTE: In accordance with the North Carolina State Plan, Attachment 4.19-B, Section 2, a provider is a PPS reconciled provider if one of the following conditions apply:

- **The RHC provider was enrolled in the Medicaid program prior to January 1, 2001, elected to be PPS reconciled, and did not change their election prior to January 1, 2005.**
- **The RHC provider was newly enrolled in the Medicaid program on or after January 1, 2001.**
- **A Cost-settled Provider had a change of ownership on or after January 1, 2005.**

Lines a - e

Enter total number of **Medicaid** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1

Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2

Enter PPS rate from DHB Provider Reimbursement.

Line 3

Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Amount Received from Medicaid from DHB-5, Line 6.

Line 5

Subtract Line 4 from Line 3 If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Health Benefits*** to the address below:

**DHHS Controller's Office
Accounts Receivable – Health Benefits
2022 Mail Service Center
Raleigh, NC 27699–2022**

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

SUMMARY OF NC HEALTH CHOICE (TITLE XXI) PAYMENTS- PAGE 7 / DHB-5A

The purpose of this schedule is to identify NC Health Choice Received / Receivable amounts and provider numbers for which NC TRACKS rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Carolina Access, Medicaid crossover and Medicaid Pregnancy Medical Home Incentive Payments (S0280 / S0281) are excluded. Co-payments for Ambulatory Services are included.**

Column 2

Lines 1a - 1h

Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2

Enter Received / Receivable amount for Core Services based on the facility's records.

Line 3

Enter Received / Receivable Third Party Liability amount for Ambulatory and Core Services based on the facility's records.

Line 4

Subtotal Lines 1a - 1h, Line 2, and Line 3.

Line 5

Enter Received / Receivable amount for Physician Hospital Services and Health Check Coordinator from Lines 1f and 1g.

Line 6

Compute Total Health Choice Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DHB-9A / Page 12, Column 3, Line 4.

Column 3

Lines 1a - 1h

Enter NPI numbers used by NC TRACKS to make payments for each Ambulatory Service. Please note, if more space is needed, provider numbers may be listed in the comments section at the bottom of the page.

Line 2

Enter NPI numbers used by NC TRACKS to make payments for Core Services.

Line 3

Enter NPI numbers which Third Party Liability payments were made for Medicaid covered services.

Comments

Use this section as needed. For example, cost reports with multiple providers may list the provider numbers here if column 3, lines 1a-1h has insufficient space.

**DHB RHC MEDICAID SCHEDULES
INSTRUCTIONS**

NC HEALTH CHOICE (TITLE XXI) PPS RECONCILIATION SCHEDULE - PAGE 12 / DHB-9A

The purpose of this schedule is to compute PPS payments for Health Choice providers based on the number of Healthchoice Encounters and identify Gross Amount Due Provider or Program.

Lines a - e

Enter total number of **HEALTH CHOICE** encounters furnished by the provider for each Ambulatory Service. This information is from the providers records.

Line 1

Compute Total HEALTH CHOICE Encounters. Enter subtotal of lines a - e.

Line 2

Enter PPS rate from DHB Rate Setting.

Line 3

Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4

Enter Amount Received from HEALTH CHOICE from DHB-5A, Line 6.

Line 5

Subtract Line 4 from Line 3 If this is a negative amount; no further action is necessary.

After completing all schedules, print and complete the Certification Form as instructed below:

CERTIFICATION STATEMENT

Enter the full name of the facility and reporting period covered by the report.

Ensure the Certification Statement is signed by an officer or administrator of the facility after all schedules have been completed. The Audit Section **must** have an original signature on the submitted form or the cost report will be considered incomplete.

QUESTIONS ABOUT COST REPORT PREPARATION:

If you have questions about the preparation of the **RHC** cost reporting forms, please contact Joy Liu at (919) 814-0022 or email Joy.Liu@dhhs.nc.gov.

**DHB RHC
MEDICAID COST REPORT
CHECKLIST**

PPS-Reconciled providers must submit a full copy of your signed and certified facility Medicare cost report (CMS 222-17) **along with your original Medicaid RHC cost report.**

For **Cost-Settled providers**, the following information **must** be submitted **along with your original Medicaid RHC cost report:**

_____ A full copy of your signed and certified facility Medicare cost report (CMS 222-17).

_____ A copy of your facility “crosswalk” working trial balance to support Medicare report.

_____ Supporting documentation and working papers including calculation of costs for the Medicare cost report.

_____ Supporting documentation and working papers including calculation of costs for the Medicaid cost report.

_____ Defined chart of accounts.

_____ Log of bad debts, if applicable.

_____ Log of vaccines administered to Medicaid beneficiaries included on DHB-7. This log must include each beneficiary’s Medicaid ID number and Date of Birth.

_____ Financial Statements, audited or unaudited, at time of submission.

_____ List of all State and Federal grant revenues. Please list the title of the grant and amount of revenues received during the reporting period.