Status:	As Filed (Provider Version)	X	Desk Reviewed	
	Revised Desk Reviewed		Field Audited	

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2017 HOSPITAL BASED RURAL HEALTH CLINIC

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

3. NPI Provider No.:	Medicaid Provider No.:	NPI Provider No.:	Medicaid Provider No.:

4. 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)	

5. If we have questions regarding the cost report, who should we contact?		6. 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:		City:	
Contact Name:		Zip Code:	
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 _____

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	ANALYSIS OF DIRECT CORE COSTS 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	(1)	(2)
1. Total Direct Cost (Medicare Cost Report, Worksheet A, Line 88)*		
2. Less: Other Ambulatory Services (Non-Core)**		
a. Pharmacy		
b. Dental		
c. Health Check Services (Formerly EPSDT)		
d. Radiology Services (on-site)		
e. Norplant Services		
f. Physician Hospital Services		
g. Other (Specify)		
3. Total Cost of Other Ambulatory Services (Sum Lines 2a - 2i)		
4. Net Direct Core Costs (Line 1 - Line 3)		

(DMA-HB3, Line 1a)

* NOTE: Use data from the Rural Health Clinic line(s) on the Medicare Cost Report. If there are multiple Rural Health Clinics at the hospital, a consolidated Medicaid RHC cost report may be prepared, or a a separate cost report may be completed for each clinic.

** From Provider Records

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	ANALYSIS OF ALLOCATED CORE COSTS 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	Total Cost	Allocated Core Ratio (From Line 5)	Allocated Core Cost (Col. 1 x Col. 2)
	(1)	(2)	(3)
1. Allocated General Service Costs (Medicare Cost Report, Worksheet B, Part 1, Line 88)*			
a. Capital-Related Costs - Buildings & Fixtures (Col. 1)			
b. Capital-Related Costs - Moveable Equipment (Col. 2)			
c. Employee Benefits (Col. 4)			
d. Administrative & General (Col. 5)			
e. Maintenance & Repairs (Col. 6)			
f. Operation & Maintenance of Plant (Col. 7)			
g. Laundry & Linen (Col. 8)			
h. Housekeeping (Col. 9)			
i. Dietary (Col. 10)			
j. Cafeteria (Col. 11)			
k. Maintenance of Personnel (Col. 12)			
l. Nursing Administration (Col. 13)			
m. Central Services & Supply (Col. 14)			
n. Pharmacy (Col. 15)			
o. Medical Records (Col. 16)			
p. Social Services (Col. 17)			
q. Other General Service (Col. 18)			
r. Nonphysician Anesthetists (Col. 19)			
s. Nursing School (Col. 20)			
t. Interns & Residents (Col. 21 & Col. 22)			
u. Paramedical Education (Col. 23)			
2. Total Allocated General Service Costs (Sum Lines 1a - 1w)			(DMA-HB3, Line 1b)
3. Total Allocated Core General Service Costs (Amount of Line 2 applicable to Core Costs) Plus all pharmacy costs			
4. Total Allocated Non-Core General Service Costs (Line 2 - Line 3)			(DMA-HB4, Line 3)
5. Ratio of Core General Service Costs / Total General Service Costs DMA-HB1, Line 4 / Line 1			(Lines 1a -1w, Column 2)

* See (*) Note on DMA-HB1

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	COST OF MEDICAID CORE SERVICES 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

	FYE 2017
1. Total Core Services Cost	
a. Direct (DMA-HB1, Line 4, Col. 2)	
b. Indirect (DMA-HB2, Line 2, Col. 3)	
c. Total (Line 1a + 1b)	
2. Total Visits (Provider Records)	
3. Cost Per Visit (Line 1c / Line 2)	

	2016 (1)	2017 (2)	TOTAL (3)
4. Medicare Upper Payment Limit Per Visit (per HCFA Transmittal A-99-8).....			
5. Medicaid Rate Covered Visits (Lessor of Lines 3 and 4)			
6. Medicaid Covered Visits for Core Services (Provider Records) ..... Including Mental Health Services.....			
7. Medicaid Cost for Core Services (Line 5 x 6)			

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	ALLOCATION OF OVERHEAD COST 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Cost Per DMA-HB1 (2)	Overhead Cost (Line 4, Col 2 x Lines 1a-1i Col 2) (3)	Total Cost (Col 2 + 3) (4)	Total Encounters/ Units of Service (Provider Records) (5)	Cost Per Encounter (Col 4 / 5) (6)
1. RHC/FQHC Ambulatory Services					
a. Pharmacy *					
b. Dental **					
c. Health Check Services (Formerly EPSDT)**					
d. Radiology Services (on-site) ***					
e. Norplant Services **					
f. Physician Hospital Services ***					
g. Other (Specify) ***					
2. Total Cost (Lines 1a-1g)					
3. Overhead Cost (DMA-HB2, Line 4)					
4. Unit Cost Multiplier (3 / 2)					

* Number of prescriptions
** Number of Encounters
*** Number of Units of Service

SCHEDULE DMA-HB5

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	DETERMINATION OF MEDICAID REIMBURSEMENT 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Cost Per Encounter (From DMA-HB4) (2)	Medicaid Encounters (Provider Records) (3)	Medicaid Cost (Col 2 x 3) (4)	
1. RHC/FQHC Services				
a. Pharmacy				
b. Dental				
c. Health Check Services (Formerly EPSDT)** . .				
d. Radiology Services (on-site)				
e. Norplant Services				
f. Physician Hospital Services				
g. Other (Specify)				
2. Subtotal				
3. Medicaid Core Service Cost				(DMA-HB3, Line 7)
4. Medicaid Cost of Pneumococcal and Influenza Vaccine				(DMA-HB8, Line 4)
5. Total Reimbursable Cost (Line 2 + 3 + 4)				
6. Amount Received/Receivable from Medicaid (Provider Records)				(DMA-HB6, Line 4)
7. Amount Due Provider <Program> Exclusive of Bad Debts (Line 5 - 6)				
8. Reimbursable Bad Debts				(DMA-HB7, Line 5)
9. Total Amount Due Provider (Program) (Line 7 + 8)				

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	SUMMARY OF MEDICAID PAYMENTS 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Amount * Received / Receivable (Provider Records) (2)	Provider Number/s (3)	
1. RHC/FQHC Payments			
a. Pharmacy			
b. Dental			
c. Health Check Services (Formerly EPSDT) .			
d. Radiology Services (on-site).			
e. Norplant Services			
f. Physician Hospital Services			
g. Other (Specify)			
2. Core Services			
3. Third Party Liability			
4. Total Medicaid Payments			(DMA-HB5, Line 6)

*** Note:** Do Not Include:

Co-Payments billed for Core Services
Fees billed for Carolina Access
Medicare Crossover Payments

*** Note:** Include: Co-Payments billed for Ambulatory Services

Comments:

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	BAD DEBTS 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Amount (2)	
1. Co-Payment Billed to Medicaid Patients (Provider Records)		
2. Co-Payment Amounts Received From Medicaid Patients (Provider Records)		
3. Medicaid Bad Debts (Line 1 - 2)		
4. Less Medicaid Bad Debt Recoveries (Provider Records)		
5. Net Bad Debts (Line 3 - 4)		(DMA-HB5, Line 8)

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES 2017 COST REPORT HOSPITAL BASED	Reporting Period From: To:

(1)	Pneumococcal (2)	Influenza (3)
1. Cost Per Pneumococcal and Influenza Vaccine Injection (Provider Records)		
2. Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicaid Beneficiaries (Provider Records)		
3. Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Line 1 x 2)		
4. Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections and their Administration (Sum of Line 3, Columns 2 and 3) Transfer to Schedule DMA-HB5, Line 4		

RUN DATE: 8/15/17

NPI NO. PROVIDER N	PPS RECONCILIATION SCHEDULE **COST SETTLED PROVIDERS ONLY** 2017 COST REPORT	Reporting Period From: To:

	Encounters	
a. Core Services		
b. Dental		
c. Health Check Services		
d. Norplant		
e. Home Health		
1. Total Encounters (Sum of Lines a-e)		
2. PPS Rate		
3. Prospective Payments with PPS Rate (Line 1 x 2)		
4. Total Reimbursable Cost from DMA-HB5		(DMA-HB5, Line 5 + DMA-HB5, Line 8)
5. Greater of PPS Payment or Reimbursable Cost		**Cost Settlement**
6. Amount Received from Medicaid		(DMA-HB6, Line 4)
7. Gross Amount Due Provider <Program>* (Line 5 - Line 6).		

* Amount due Program must be remitted under separate cover with check made payable to ***Division of Medical Assistance*** to the address below:

DHHS Controller's Office
Accounts Receivable Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699-2022

Settlement is in accordance with North Carolina Medicaid State Plan Attachment 4.19-B Section 2.

NOTE: IF PROVIDER IS PPS RECONCILED, COMPLETE DMA-HB10-A FOR THE PPS RECONCILIATION.

RUN DATE: 8/15/17 SCHEDULE DMA-HB10-A

NPI NO.	PPS RECONCILIATION SCHEDULE	Reporting Period
	PPS RECONCILED PROVIDERS ONLY	From:
PROVIDER NO.	2017 COST REPORT	To:
	HOSPITAL BASED	

	Encounters		
a. Core Services			
b. Dental			
c. Health Check			
d. Norplant			
e. Home Health			
1. Total Encounters (Sum of Lines a-e)			
2. PPS Rate			
3. Total Prospective Payments with PPS Rate (Line 1 x Line 2)			
4. Amount Received from Medicaid			(DMA-HB6, Line 4)
5. Gross Amount Due Provider <Program>*			(Line 3 - Line 4)

***** Amount due program must be remitted under separate cover with check made payable to ***Division of Medical Assistance*** to the address below:

DHHS Controller's Office
Accounts Receivable Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699-2022

Settlement is in accordance with North Carolina Medicaid State Plan Attachment 4.19-B Section 2.

NOTE: IF PROVIDER IS COST SETTLED, COMPLETE DMA-HB9 FOR THE PPS RECONCILIATION.

NPI NO.	0
PROVIDER NO.	0

SCOPE OF SERVICE CHANGES
PPS RECONCILED PROVIDERS ONLY
2017 COST REPORT
HOSPITAL BASED

Reporting Period:	
From:	1/0/1900
To:	1/0/1900

(1)	**No Change** (2)	**Added Service** (3)	**Date Added** (4)	**Discon-tinued Service** (5)	**Date Discon-tinued** (6)
1. RHC Lines of Service					
a. Pharmacy					
b. Dental.					
c. Health Check Services (formerly EPSDT)					
d. Maternity Care Coordination					
e. Child Services Coordination					
f. Radiology Services (on-site)					
g. Norplant Services.					
i. Health Check Coordinator					
j. Durable Medical Equipment.					
i. Home Health					
j. Other (Specify)					

Comments:

Please provide one form per NPI annually.