

1  
2 North Carolina Division of Medical Assistance  
3 Local Health Department Cost Report  
4  
5

6 **SECTION I - COST REPORT ATTESTATION**

7  
8 **Complete Shaded Areas**  
9

10 1. Governmental Provider Name and Address:  
11  
12  
13  
14 Federal Employer Identification Number:  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24

Type of Submission: <input type="checkbox"/> Original Cost Report <input type="checkbox"/> Amended Cost Report - Reason:	Primary	NPI Number	Medicaid Provider Number

25 2a. Reporting Period (Medicaid State Plan Rate Year):  
26 From: 7/1/2016  
27 To: 6/30/2017  
28  
29  
30

2b. Type of Provider (Check One)  
 Local Health Department  
 CDSA  
 Other

31 3 a. Type of Report:  
32  
33  Partial Period Report  
34  Quarterly Cost Report  
35  Full Year Cost Report  
36  
37  
38  
39  
40

b. Cost by Component:

	Medicaid Medical Services	Medicaid Family Planning Services	NC Health Choice Services	Medicaid Administration (Approved MAC Plan)
Total Gross Computable Expenditure (Exhibit 1b)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Net Computable Expenditure (Exhibit 1b)	#DIV/0!	#DIV/0!	#DIV/0!	\$0
<b>Total Net Computable Settlement (FMAP/FFP Applied) (Exhibits 1b)</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>\$0</b>

41  
42  
43  
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47 **PART I CERTIFICATION**

48 **CERTIFICATION BY OFFICER OF THE PROVIDER**

49 I HEREBY CERTIFY that:  
50  
51  
52 1 I have examined this statement, the accompanying Supporting Schedules, the allocation of expenses and  
53 services, and the attached Worksheets for the period from 7/1/2016 to 6/30/2017  
54 and that to the best of my knowledge and belief they are true and correct statements prepared from the books and  
55 records of the provider in accordance with applicable instructions.  
56 2 The expenditures included in this statement are based on the actual total cost of recorded expenditures including  
57 the federal and non-federal share.  
58 3 The required amount of state and/or local funds were available and used to pay for total computable allowable  
59 expenditures included in this statement, and as such state and/or local funds were in accordance with all applicable  
60 federal requirements for the non-federal share match of expenditures (including that the funds were not Federal funds  
61 in origin, or are Federal funds authorized by Federal law to be used to match other Federal funds, and that the claimed  
62 expenditures were not used to meet matching requirements under other Federally funded programs).  
63 4 Federal matching funds are being claimed on this report in accordance with the Cost Report instructions provided by  
64 the NC Department of Health & Human Services effective for the above reporting period.  
65 5 I am the officer authorized by the referenced government agency to submit this form and I have made a good faith effort  
66 to assure that all information reported is true and accurate.  
67 6 I understand that this information will be used as a basis for claims for federal funds, and possibly state funds, and that  
68 falsification and concealment of a material fact may be prosecuted under federal or state civil or criminal law.  
69

70  
71 SIGNATURE (Officer of the Government Agency) DATE  
72  
73 Health Director TITLE PHONE NUMBER  
74  
75

North Carolina Division of Medical Assistance  
Local Health Department Cost Report  
COST REPORT SUMMARY

**Complete Shaded Areas Only**

1. **Governmental Provider Name and Address:**

0
0
0

Primary NPI Number:

Medicaid Provider Number:

2. **Reporting Period and Approval:**

From:   
To:

Approved For Submittal to DMA By:  1/0/1900

Name of Officer Authorized to Sign Cost Report \_\_\_\_\_ Position Title \_\_\_\_\_ Date \_\_\_\_\_

Name of Contact Person  Telephone No.:

Email Address:  Fax No.:

3a. **Type of Report:**

- Partial Period Report
- Quarterly Cost Report
- Full Year Cost Report

3b. **Total Reported Costs**

Total Facility Expenditures After Reclassification	
Administration / Support (From Exhibit 5)	\$ -
Clinical Administration / Support (From Exhibit 5)	\$ -
Direct Medical Care / Clinic (From Exhibit 5)	\$ -
Non Reimbursable (From Exhibit 5)	\$ -
<b>Total Expenditures</b>	<b>\$ -</b>

3c. **Cost Claimed by Component:**

	Medicaid Clinic Settlement	Medicaid Family Planning Settlement	NC Health Choice Settlement	Medicaid Administration (Approved MAC Plan)
Physicians / PE / Case Managers / Billing / Intake (From Exhibit 9a & 9b)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Nurses (From Exhibit 9a & 9b)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Social Workers (From Exhibit 9a & 9b)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Health Educators & Nutritionists (From Exhibit 9a & 9b)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Lab Services (From Exhibit 9a)	#DIV/0!	#DIV/0!	#DIV/0!	NA
<b>Gross Computable Medicaid Expenditure (From Exhibit 9a &amp; 9b)</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>
Total Medicaid Interim Payments (From Exhibits 9a & 9b)	\$0	\$0	\$0	\$0
<b>Total Net Computable Medicaid Expenditures</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>\$0</b>
FMAP/FFP	66.72%	90.00%	99.71%	50.00%
<b>NET COMPUTABLE SETTLEMENT (FMAP Applied)</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>#DIV/0!</b>	<b>\$0</b>
<b>TOTAL MEDICAID ADMIN CLAIMS FOR FISCAL YEAR (From Exhibit 9b)</b>				<b>\$0</b>
<b>NET MAC SETTLEMENT AMOUNT</b>				<b>\$0</b>

	A	B	C	D	E
1	<b>North Carolina Division of Medical Assistance</b>				
2	<b>Local Health Department Cost Report</b>				
3	#		Primary NPI Number	0	
			Medicaid Provider Number	0	
4	<b>STATISTICAL INFORMATION</b>				
5	<b>Period for Statistics</b>				
6		Fiscal Year Start Date	7/1/2016		
7		Fiscal Year End Date	6/30/2017		
8					
9					
10					
11	<b>Complete Shaded Areas Only</b>				
12					
13	<b>Total Medicaid Charges - Applicable Period</b>			-	
14	<b>Total Charges - Applicable Period</b>				
15	<b>Total Medicaid Charges to Total Charges</b>			#DIV/0!	
16					
17	<b>Medicaid Charges</b>			<b>Total Amount</b>	<b>Percent of Total</b>
18	<b>Total Family Planning Medicaid Charges - Applicable Period</b>				#DIV/0!
19	<b>Total Family Planning Waiver Medicaid Charges - Applicable Period</b>				#DIV/0!
20	<b>Total Clinical Medicaid Charges - Applicable Period</b>				#DIV/0!
21		<b>TOTAL</b>	<b>\$</b>	<b>-</b>	<b>#DIV/0!</b>
22					
23	<b>Total NC Health Choice Charges - Applicable Period</b>				
24	<b>Total Charges - Applicable Period</b>			-	
25	<b>Total NC Health Choice Charges to Total Charges</b>			#DIV/0!	
26					
27	<b>Time Reporting Information</b>				
28	<b>Type of Time Report</b>			<b>Actual Time Reporting</b>	
29	<b>Period of Time Reporting</b>				
30					

A	B	C	D	E	F	G	H	I	J		
1	<b>North Carolina Division of Medical Assistance</b>							Primary NPI Number	0		
2	<b>Local Health Department Cost Report</b>							Medicaid Provider Number	0		
3	<b>Actual Time Study Results &amp; Reallocation of General Administrative Time</b>							Reporting Period	From: 7/1/2016		
4	0							To:	6/30/2017		
5											
6	<b>Complete Shaded Areas Only</b>										
7											
8	<b>LOCAL HEALTH DEPARTMENT ACTUAL TIME RESULTS - APPLICABLE GROUPING</b>										
9	<b>Nurses Actual Time Grouping</b>										
10											
11					Enter **	Activity %	After Reallocation	Direct	Administrative %		
12	Time Study Data				Type	from	of	Medical %	Direct	Discounted	Medicaid
13					Activity	Actual Time	Gen. Admin.		Administrative %	Rate	Administrative
14									(From Exhibit 2)	(Col. G x Col. H)	
15											
16	Direct Clinical Service Activity				1				0.00%		0.00%
17	Behavioral Health Direct Clinical Service Activity				1				0.00%		0.00%
18	Non Clinical Service Activity				4				0.00%		0.00%
19	Laboratory Direct Service Activity				4				0.00%		0.00%
20	Referral and Coordination of Care Coordination for Children (CC4C)				4				0.00%		0.00%
21	Referral and Coordination of Pregnancy Care Management (PCM)				4				0.00%		0.00%
22	Paid Time Off (Vacation, Paid Leave, etc.)				3			0.00%	0.00%		0.00%
23	General Administration - Clinical Related (Meetings, Training and Development)				3			0.00%	0.00%		0.00%
24											
25	<b>Total Allocation Percentage</b>					<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>			<b>0.00%</b>
26											
27	Enter code (1-4) for type of activity **										
28	Enter if activity is for Direct Medical 1										
29	Enter if Medicaid activity is for Direct Administrative 2										
30	Enter if activity is General Administration for reallocation 3										
31	Enter if activity is Non-Medicaid 4										
32											
33	<b>Social Workers Actual Time Grouping</b>										
34											
35					Enter **	Activity %	After Reallocation	Direct	Administrative %		
36	Time Study Data				Type	from	of	Medical %	Direct	Discounted	Medicaid
37					Activity	Actual Time	Gen. Admin.		Administrative %	Rate	Administrative
38									(From Exhibit 2)	(Col. G x Col. H)	
39											
40	Direct Clinical Service Activity				1				0.00%		0.00%
41	Behavioral Health Direct Clinical Service Activity				1				0.00%		0.00%
42	Non Clinical Service Activity				4				0.00%		0.00%
43	Laboratory Direct Service Activity				4				0.00%		0.00%
44	Referral and Coordination of Care Coordination for Children (CC4C)				4				0.00%		0.00%
45	Referral and Coordination of Pregnancy Care Management (PCM)				4				0.00%		0.00%
46	Paid Time Off (Vacation, Paid Leave, etc.)				3				0.00%		0.00%
47	General Administration - Clinical Related (Meetings, Training and Development)				3				0.00%		0.00%
48											
49	<b>Total Allocation Percentage</b>					<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>			<b>0.00%</b>
50											
51	Enter code (1-4) for type of activity **										
52	Enter if activity is for Direct Medical 1										
53	Enter if Medicaid activity is for Direct Administrative 2										
54	Enter if activity is General Administration for reallocation 3										
55	Enter if activity is Non-Medicaid 4										
56											
57	<b>Health Educators &amp; Nutritionists Actual Time Grouping</b>										
58											
59					Enter **	Activity %	After Reallocation	Direct	Administrative %		
60	Time Study Data				Type	from	of	Medical %	Direct	Discounted	Medicaid
61					Activity	Actual Time	Gen. Admin.		Administrative %	Rate	Administrative
62									(From Exhibit 2)	(Col. G x Col. H)	
63											
64	Direct Clinical Service Activity				1				0.00%		0.00%
65	Behavioral Health Direct Clinical Service Activity				1				0.00%		0.00%
66	Non Clinical Service Activity				4				0.00%		0.00%
67	Laboratory Direct Service Activity				4				0.00%		0.00%
68	Referral and Coordination of Care Coordination for Children (CC4C)				4				0.00%		0.00%
69	Referral and Coordination of Pregnancy Care Management (PCM)				4				0.00%		0.00%
70	Paid Time Off (Vacation, Paid Leave, etc.)				3				0.00%		0.00%
71	General Administration - Clinical Related (Meetings, Training and Development)				3				0.00%		0.00%
72											
73	<b>Total Allocation Percentage</b>					<b>0.00%</b>	<b>0.00%</b>	<b>0.00%</b>			<b>0.00%</b>
74											
75	Enter code (1-4) for type of activity **										
76	Enter if activity is for Direct Medical 1										
77	Enter if Medicaid activity is for Direct Administrative 2										
78	Enter if activity is General Administration for reallocation 3										
79	Enter if activity is Non-Medicaid 4										
80											
81											

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	<b>North Carolina Division of Medical Assistance</b>												
2	<b>Local Health Department Cost Report</b>												
3	<b>LHD Administration / Support Costs by Discipline</b>												
4	<b>0</b>												
5	<b>Complete Shaded Areas Only</b>												
6													
7	All Expenditures Come from Financial Statements												
8													
9	<b>Period for Expenditures</b>												
10	Fiscal Year Start Date	7/1/2016		Primary NPI Number	0								
11	Fiscal Year End Date	6/30/2017		Medicaid Provider Number	0								
12													
13	<b>SECTION I. Personnel / Staff Expenditures</b>												
14	<b>Personnel Cost Center Information</b>												
15	<b>Cost Center Name</b>				<b>Salary and Benefits</b>								
16	110XX Health Director's Office and Staff				Total Gross Salary 11000	Employee Benefits 11010	Employer- FICA (if not covered under employee benefits) 11015	Medicare Tax -Employer - (if not listed under employee benefits) 11020	Other Benefits / Vendor or Contractor Payments 11025	TOTAL SALARY AND BENEFITS			
17	Trial Balance Amount (From Financial Statements)									\$0.00			
18	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
19	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
20	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
21													
22												\$0.00	
23												\$0.00	
24												\$0.00	
25												\$0.00	
26												\$0.00	
27	<b>TOTAL REDUCTIONS</b>				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$0.00</b>		
28													
29	<b>Cost Center Name</b>				<b>Salary and Benefits</b>								
30	120XX Finance Office and Staff				Total Gross Salary 12000	Employee Benefits 12010	Employer- FICA (if not covered under employee benefits) 12015	Medicare Tax -Employer - (if not listed under employee benefits) 12020	Other Benefits / Vendor or Contractor Payments 12025	TOTAL SALARY AND BENEFITS			
31	Trial Balance Amount (From Financial Statements)									\$0.00			
32	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
33	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
34	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
35													
36												\$0.00	
37												\$0.00	
38												\$0.00	
39												\$0.00	
40												\$0.00	
41	<b>TOTAL REDUCTIONS</b>				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$0.00</b>		
42													
43	<b>Cost Center Name</b>				<b>Salary and Benefits</b>								
44	130XX Other Personnel				Total Gross Salary 13000	Employee Benefits 13010	Employer- FICA (if not covered under employee benefits) 13015	Medicare Tax -Employer - (if not listed under employee benefits) 13020	Other Benefits / Vendor or Contractor Payments 13025	TOTAL SALARY AND BENEFITS			
45	Trial Balance Amount (From Financial Statements)									\$0.00			
46	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
47	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
48	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
49													
50												\$0.00	
51												\$0.00	
52												\$0.00	
53												\$0.00	
54												\$0.00	
55	<b>TOTAL REDUCTIONS</b>				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	<b>\$0.00</b>		

1	<b>North Carolina Division of Medical Assistance</b>												
2	<b>Local Health Department Cost Report</b>												
3	<b>LHD Administration / Support Costs by Discipline</b>												
4	<b>0</b>												
5	<b>Complete Shaded Areas Only</b>												
6													
7	All Expenditures Come from Financial Statements												
8													
9	<b>Period for Expenditures</b>												
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number	0									
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number	0									
12													
56													

**SECTION II. Operating Expenditures**

57	<b>SECTION II. Operating Expenditures</b>												
58	<b>Operating Cost Center Information</b>												
59	<b>Cost Center Name</b>												
60	<b>14800 Supplies - LHD Admin / Support</b>												
61	<b>Trial Balance Amount (From Financial Statements)</b>												
62	<b>Reductions to Trial Balance</b>												
63	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
64	<b>Trial Balance Account Number</b>	<b>Account Description</b>	<b>Is position funded by Federal funds? Yes or No</b>	<b>Enter Amount of Operating Expenditure to be Removed from Cost Center</b>	<b>Add: State/Local Match required for Federal Funds</b>	<b>Other amounts to be removed</b>	<b>TOTAL Amount to be Reduced from Cost Center</b>	<b>Identify COST CENTER Where Reduction Amount Will Be Moved</b>	<b>Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5</b>				
65							\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
66							\$0.00						
67							\$0.00						
68							\$0.00						
69							\$0.00						
70							\$0.00						
71					\$0.00	\$0.00	\$0.00	\$0.00					
72													
73	<b>Cost Center Name</b>												
74	<b>15000 Capital Expenditures - LHD Admin / Support</b>												
75	<b>Trial Balance Amount (From Financial Statements)</b>												
76	<b>Reductions to Trial Balance</b>												
77	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
78	<b>Trial Balance Account Number</b>	<b>Account Description</b>	<b>Is position funded by Federal funds? Yes or No</b>	<b>Enter Amount of Operating Expenditure to be Removed from Cost Center</b>	<b>Add: State/Local Match required for Federal Funds</b>	<b>Other amounts to be removed</b>	<b>TOTAL Amount to be Reduced from Cost Center</b>	<b>Identify COST CENTER Where Reduction Amount Will Be Moved</b>	<b>Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5</b>				
79							\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
80							\$0.00						
81							\$0.00						
82							\$0.00						
83							\$0.00						
84							\$0.00						
85					\$0.00	\$0.00	\$0.00	\$0.00					
86													
87	<b>Cost Center Name</b>												
88	<b>16000 Contracted Services - LHD Admin / Support</b>												
89	<b>Trial Balance Amount (From Financial Statements)</b>												
90	<b>Reductions to Trial Balance</b>												
91	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
92	<b>Trial Balance Account Number</b>	<b>Account Description</b>	<b>Is position funded by Federal funds? Yes or No</b>	<b>Enter Amount of Operating Expenditure to be Removed from Cost Center</b>	<b>Add: State/Local Match required for Federal Funds</b>	<b>Other amounts to be removed</b>	<b>TOTAL Amount to be Reduced from Cost Center</b>	<b>Identify COST CENTER Where Reduction Amount Will Be Moved</b>	<b>Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5</b>				
93							\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
94							\$0.00						
95							\$0.00						
96							\$0.00						
97							\$0.00						
98							\$0.00						
99					\$0.00	\$0.00	\$0.00	\$0.00					

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	<b>North Carolina Division of Medical Assistance</b>												
2	<b>Local Health Department Cost Report</b>												
3	<b>LHD Administration / Support Costs by Discipline</b>												
4	<b>0</b>												
5	<b>Complete Shaded Areas Only</b>												
6													
7	All Expenditures Come from Financial Statements												
8													
9	<b>Period for Expenditures</b>												
10	Fiscal Year Start Date	7/1/2016		Primary NPI Number	0								
11	Fiscal Year End Date	6/30/2017		Medicaid Provider Number	0								
12													
100													
101	<b>Cost Center Name</b>												
102	<b>17000 Other Operating Expenditures - LHD Admin / Support</b>												
103	<b>Trial Balance Amount (From Financial Statements)</b>												
104	<b>Reductions to Trial Balance</b>												
105	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
106	<b>Expenditure Information</b>												
107	Trial Balance Account Number	Account Description			Is position funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5		
108									\$0.00	Select from Dropdown Menu	Select from Dropdown Menu		
109									\$0.00				
110									\$0.00				
111									\$0.00				
112													
113						\$0.00	\$0.00	\$0.00	\$0.00				
114													
115	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>												
116	<b>Cost Center Information</b>												
117	<b>Expenditure Information</b>												
118	Trial Balance Account Number	Account Description			Adjustment / Transfer	Enter Amount of Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5		
119					TOTAL Amount to be Transferred to Trial Balance					Select from Dropdown Menu	Select from Dropdown Menu		
120		18500 Depreciation Expense - LHD Admin / Support							\$0.00				
121		18600 Indirect Costs from CAP							\$0.00				
122					\$0.00	\$0.00	\$0.00	\$0.00	\$0.00				
123													
124													
125													
126													

	A	B	C	D	E	F	G	H	I	J	K	L	M			
1	<b>North Carolina Division of Medical Assistance</b>															
2	<b>Local Health Department Cost Report</b>															
3	<b>Clinical Administration / Support Costs by Discipline</b>															
4	<b>0</b>															
5	<b>Complete Shaded Areas Only</b>															
6																
7	All Expenditures Come from Audited Financial Statements															
8																
9	<b>Period for Expenditures</b>															
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0											
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0											
12																
13	<b>SECTION I. Personnel / Staff Expenditures</b>															
14	<b>Personnel Cost Center Information</b>															
15	<b>Cost Center Name</b>					<b>Salary and Benefits</b>										
16	<b>210XX Nursing Director's Office and Clinical Supervisor Staff</b>					Total Gross Salary	21000	Employee Benefits	21010	Employer- FICA (if not covered under employee benefits)	21015	Medicare Tax -Employer - (if not listed under employee benefits)	21020	Other Benefits / Vendor or Contractor Payments	21025	TOTAL SALARY AND BENEFITS
17	Trial Balance Amount (From Financial Statements)															\$0.00
18	<b>Reductions to Trial Balance</b>															
19	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
20	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits				
21																
22												\$0.00				
23												\$0.00				
24												\$0.00				
25												\$0.00				
26						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			
27																
28																
29	<b>Cost Center Name</b>					<b>Salary and Benefits</b>										
30	<b>220XX Billing Office and Staff</b>					Total Gross Salary	22000	Employee Benefits	22010	Employer- FICA (if not covered under employee benefits)	22015	Medicare Tax -Employer - (if not listed under employee benefits)	22020	Other Benefits / Vendor or Contractor Payments	22025	TOTAL SALARY AND BENEFITS
31	Trial Balance Amount (From Financial Statements)															\$0.00
32	<b>Reductions to Trial Balance</b>															
33	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
34	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits				
35																
36												\$0.00				
37												\$0.00				
38												\$0.00				
39												\$0.00				
40						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			
41																
42																
43	<b>Cost Center Name</b>					<b>Salary and Benefits</b>										
44	<b>230XX Interpreters</b>					Total Gross Salary	23000	Employee Benefits	23010	Employer- FICA (if not covered under employee benefits)	23015	Medicare Tax -Employer - (if not listed under employee benefits)	23020	Other Benefits / Vendor or Contractor Payments	23025	TOTAL SALARY AND BENEFITS
45	Trial Balance Amount (From Financial Statements)															\$0.00
46	<b>Reductions to Trial Balance</b>															
47	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
48	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits				
49																
50												\$0.00				
51												\$0.00				
52												\$0.00				
53												\$0.00				
54						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00			
55																



	A	B	C	D	E	F	G	H	I	J	K	L	M	
1	<b>North Carolina Division of Medical Assistance</b>													
2	<b>Local Health Department Cost Report</b>													
3	<b>Clinical Administration / Support Costs by Discipline</b>													
4	<b>0</b>													
5	<b>Complete Shaded Areas Only</b>													
6														
7	All Expenditures Come from Audited Financial Statements													
8														
9	<b>Period for Expenditures</b>													
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0									
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0									
12														
56														
57	<b>Cost Center Name</b>			<b>Salary and Benefits</b>										
58	<b>240XX Other Personnel</b>			Total Gross Salary	24000	Employee Benefits	24010	Employer- FICA (if not covered under employee benefits)	24015	Medicare Tax -Employer - (if not listed under employee benefits)	24020	Other Benefits / Vendor or Contractor Payments	24025	TOTAL SALARY AND BENEFITS
59	Trial Balance Amount (From Financial Statements)													
60	<b>Reductions to Trial Balance</b>													
61	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>								
62	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits		
63														
64													\$0.00	
65													\$0.00	
66													\$0.00	
67													\$0.00	
68														
69	TOTAL REDUCTIONS			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
70														
71														
72	<b>SECTION II. Operating Expenditures</b>													
73	<b>Operating Cost Center Information</b>													
74	<b>Cost Center Name</b>													
75	<b>24800 Supplies - Clinic Admin</b>			<b>TOTAL EXPENDITURES</b>										
76	Trial Balance Amount (From Financial Statements)													
77	<b>Reductions to Trial Balance</b>													
78	<b>Expenditure Information</b>					<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>								
79	Trial Balance Account Number	Account Description			Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5			
80										Select from Dropdown Menu	Select from Dropdown Menu			
81									\$0.00					
82									\$0.00					
83									\$0.00					
84									\$0.00					
85														
86	TOTAL REDUCTIONS			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
87														
88	<b>Cost Center Name</b>													
89	<b>25000 Capital Expenditures - Clinic Admin</b>			<b>TOTAL EXPENDITURES</b>										
90	Trial Balance Amount (From Financial Statements)													
91	<b>Reductions to Trial Balance</b>													
92	<b>Expenditure Information</b>					<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>								
93	Trial Balance Account Number	Account Description			Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5			
94										Select from Dropdown Menu	Select from Dropdown Menu			
95									\$0.00					
96									\$0.00					
97									\$0.00					
98									\$0.00					
99														
100	TOTAL REDUCTIONS			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	<b>North Carolina Division of Medical Assistance</b>												
2	<b>Local Health Department Cost Report</b>												
3	<b>Clinical Administration / Support Costs by Discipline</b>												
4	<b>0</b>												
5	<b>Complete Shaded Areas Only</b>												
6													
7	All Expenditures Come from Audited Financial Statements												
8													
9	<b>Period for Expenditures</b>												
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0								
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0								
12													
101													
102	<b>Cost Center Name</b>												
103	<b>26000 Contracted Services - Clinic Admin</b>												
104	<b>Trial Balance Amount (From Financial Statements)</b>												
105	<b>Reductions to Trial Balance</b>												
106	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
107	Trial Balance Account Number	Account Description	Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
108								Select from Dropdown Menu	Select from Dropdown Menu				
109							\$0.00						
110							\$0.00						
111							\$0.00						
112							\$0.00						
113													
114					\$0.00	\$0.00	\$0.00	\$0.00					
115													
116	<b>Cost Center Name</b>												
117	<b>27000 Other Operating Expenditures - Clinic Admin</b>												
118	<b>Trial Balance Amount (From Financial Statements)</b>												
119	<b>Reductions to Trial Balance</b>												
120	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
121	Trial Balance Account Number	Account Description	Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
122								Select from Dropdown Menu	Select from Dropdown Menu				
123							\$0.00						
124							\$0.00						
125							\$0.00						
126							\$0.00						
127													
128					\$0.00	\$0.00	\$0.00	\$0.00					
129													
130	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>												
131	<b>Cost Center Information</b>												
132	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
133	Trial Balance Account Number	Account Description	TOTAL Amount to be Transferred to Trial Balance	Enter Amount of Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
134								Select from Dropdown Menu	Select from Dropdown Menu				
135		29500 Depreciation Expense					\$0.00						
136													
137			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00						
138													

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	North Carolina Division of Medical Assistance												
2	Local Health Department Cost Report												
3	Direct Medical / Clinic Costs by Discipline												
4	0												
5	Complete Shaded Areas Only												
6													
7	All Expenditures Come from Audited Financial Statements												
8													
9	Period for Expenditures												
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0								
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0								
12													
13	<b>SECTION I. Personnel / Staff Expenditures</b>												
14	<b>Personnel Cost Center Information</b>												
15	<b>Cost Center Name</b>					<b>Salary and Benefits</b>							
16	310XX - Physicians (MD, PA, Nurse Practitioner)					Total Gross Salary	31000	Employee Benefits	31010	Employer- FICA (if not covered under employee benefits) 31015	Medicare Tax -Employer - (if not listed under employee benefits) 31020	Other Benefits / Vendor or Contractor Payments 31025	TOTAL SALARY AND BENEFITS
17	Trial Balance Amount (From Financial Statements)												\$0.00
18	<b>Reductions to Trial Balance</b>												
19	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>							
20	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
21													
22												\$0.00	
23												\$0.00	
24												\$0.00	
25												\$0.00	
26						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
27						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
28													
29	<b>Cost Center Name</b>					<b>Salary and Benefits</b>							
30	320XX Nurses (PHN, RN, Enhanced Role Nurse)					Total Gross Salary	32000	Employee Benefits	32010	Employer- FICA (if not covered under employee benefits) 32015	Medicare Tax -Employer - (if not listed under employee benefits) 32020	Other Benefits / Vendor or Contractor Payments 32025	TOTAL SALARY AND BENEFITS
31	Trial Balance Amount (From Financial Statements)												\$0.00
32	<b>Reductions to Trial Balance</b>												
33	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>							
34	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
35													
36												\$0.00	
37												\$0.00	
38												\$0.00	
39												\$0.00	
40						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
41						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
42													
43	<b>Cost Center Name</b>					<b>Salary and Benefits</b>							
44	330XX Social Workers					Total Gross Salary	33000	Employee Benefits	33010	Employer- FICA (if not covered under employee benefits) 33015	Medicare Tax -Employer - (if not listed under employee benefits) 33020	Other Benefits / Vendor or Contractor Payments 33025	TOTAL SALARY AND BENEFITS
45	Trial Balance Amount (From Financial Statements)												\$0.00
46	<b>Reductions to Trial Balance</b>												
47	<b>Personnel Information</b>					<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>							
48	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits	
49													
50												\$0.00	
51												\$0.00	
52												\$0.00	
53												\$0.00	
54						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
55						TOTAL REDUCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L	M		
1	<b>North Carolina Division of Medical Assistance</b>														
2	<b>Local Health Department Cost Report</b>														
3	<b>Direct Medical / Clinic Costs by Discipline</b>														
4	<b>0</b>														
5	<b>Complete Shaded Areas Only</b>														
6															
7	<b>All Expenditures Come from Audited Financial Statements</b>														
8															
9	<b>Period for Expenditures</b>														
10	Fiscal Year Start Date	7/1/2016		Primary NPI Number	0										
11	Fiscal Year End Date	6/30/2017		Medicaid Provider Number	0										
12															
56															
57	<b>Cost Center Name</b>				<b>Salary and Benefits</b>										
58	<b>340XX Health Educators &amp; Nutritionists</b>				Total Gross Salary	34000	Employee Benefits	34010	Employer- FICA (if not covered under employee benefits)	34015	Medicare Tax -Employer - (if not listed under employee benefits)	34020	Other Benefits / Vendor or Contractor Payments	34025	TOTAL SALARY AND BENEFITS
59	Trial Balance Amount (From Financial Statements)													\$0.00	
60	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
61	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
62	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits			
63															
64														\$0.00	
65														\$0.00	
66														\$0.00	
67														\$0.00	
68														\$0.00	
69	TOTAL REDUCTIONS				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
70															
71	<b>Cost Center Name</b>				<b>Salary and Benefits</b>										
72	<b>341XX Laboratory Staff (Techs, etc.)</b>				Total Gross Salary	34100	Employee Benefits	34110	Employer- FICA (if not covered under employee benefits)	34115	Medicare Tax -Employer - (if not listed under employee benefits)	34120	Other Benefits / Vendor or Contractor Payments	34125	TOTAL SALARY AND BENEFITS
73	Trial Balance Amount (From Financial Statements)													\$0.00	
74	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
75	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
76	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits			
77															
78														\$0.00	
79														\$0.00	
80														\$0.00	
81														\$0.00	
82														\$0.00	
83	TOTAL REDUCTIONS				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	
84															
85	<b>Cost Center Name</b>				<b>Salary and Benefits</b>										
86	<b>342XX Other Medical / Clinic Personnel</b>				Total Gross Salary	34200	Employee Benefits	34210	Employer- FICA (if not covered under employee benefits)	34215	Medicare Tax -Employer - (if not listed under employee benefits)	34220	Other Benefits / Vendor or Contractor Payments	34225	TOTAL SALARY AND BENEFITS
87	Trial Balance Amount (From Financial Statements)													\$0.00	
88	<b>Reductions to Trial Balance</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
89	<b>Personnel Information</b>				<b>Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center</b>										
90	Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits			
91															
92														\$0.00	
93														\$0.00	
94														\$0.00	
95														\$0.00	
96														\$0.00	
97	TOTAL REDUCTIONS				\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L	M	
1	North Carolina Division of Medical Assistance													
2	Local Health Department Cost Report													
3	Direct Medical / Clinic Costs by Discipline													
4	0													
5	Complete Shaded Areas Only													
6														
7	All Expenditures Come from Audited Financial Statements													
8														
9	Period for Expenditures													
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0									
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0									
12														
98														
99	<b>SECTION II. Operating Expenditures</b>													
100	<b>Operating Cost Center Information</b>													
101	<b>Cost Center Name</b>											<b>TOTAL EXPENDITURES</b>		
102	34800 Supplies - Medical / Clinic													
103	Trial Balance Amount (From Financial Statements)													
104	<b>Reductions to Trial Balance</b>													
105	<b>Expenditure Information</b>											<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>		
106	Trial Balance Account Number	Account Description				Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5		
107											Select from Dropdown Menu	Select from Dropdown Menu		
108										\$0.00				
109										\$0.00				
110										\$0.00				
111										\$0.00				
112										\$0.00				
113										\$0.00				
114										\$0.00				
115										\$0.00				
116										\$0.00				
117										\$0.00	\$0.00	\$0.00	\$0.00	
118														
119	<b>Cost Center Name</b>											<b>TOTAL EXPENDITURES</b>		
120	35000 Capital Expenditures - Medical / Clinic													
121	Trial Balance Amount (From Financial Statements)													
122	<b>Reductions to Trial Balance</b>													
123	<b>Expenditure Information</b>											<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>		
124	Trial Balance Account Number	Account Description				Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5		
125											Select from Dropdown Menu	Select from Dropdown Menu		
126										\$0.00				
127										\$0.00				
128										\$0.00				
129										\$0.00				
130										\$0.00				
131										\$0.00	\$0.00	\$0.00	\$0.00	
132														
133	<b>Cost Center Name</b>											<b>TOTAL EXPENDITURES</b>		
134	36000 Contracted Services - Medical / Clinic													
135	Trial Balance Amount (From Financial Statements)													
136	<b>Reductions to Trial Balance</b>													
137	<b>Expenditure Information</b>											<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>		
138	Trial Balance Account Number	Account Description				Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5		
139											Select from Dropdown Menu	Select from Dropdown Menu		
140										\$0.00				
141										\$0.00				
142										\$0.00				
143										\$0.00				
144										\$0.00				
145										\$0.00				
146										\$0.00				
147										\$0.00				
148										\$0.00				
149										\$0.00				
150										\$0.00	\$0.00	\$0.00	\$0.00	

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	<b>North Carolina Division of Medical Assistance</b>												
2	<b>Local Health Department Cost Report</b>												
3	<b>Direct Medical / Clinic Costs by Discipline</b>												
4	<b>0</b>												
5	<b>Complete Shaded Areas Only</b>												
6													
7	<b>All Expenditures Come from Audited Financial Statements</b>												
8													
9	<b>Period for Expenditures</b>												
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number		0								
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number		0								
12													
151													
152	<b>Cost Center Name</b>												
153	<b>36900 Laboratory Expenditures</b>												
154	<b>Trial Balance Amount (From Financial Statements)</b>												
155	<b>Reductions to Trial Balance</b>												
156	<b>Expenditure Information</b>												
157	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
158	Trial Balance Account Number	Account Description	Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
159							\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
160							\$0.00						
161							\$0.00						
162							\$0.00						
163							\$0.00						
164							\$0.00	\$0.00	\$0.00	\$0.00			
165													
166	<b>Cost Center Name</b>												
167	<b>37000 Other Operating Expenditures - Medical / Clinic</b>												
168	<b>Trial Balance Amount (From Financial Statements)</b>												
169	<b>Reductions to Trial Balance</b>												
170	<b>Expenditure Information</b>												
171	<b>Operating Expenditure Reductions - Amount to be Removed from Cost Center</b>												
172	Trial Balance Account Number	Account Description	Is expenditure funded by Federal funds? Yes or No	Enter Amount of Operating Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
173							\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
174							\$0.00						
175							\$0.00						
176							\$0.00						
177							\$0.00						
178							\$0.00						
179							\$0.00						
180							\$0.00						
181							\$0.00						
182							\$0.00						
183							\$0.00	\$0.00	\$0.00	\$0.00			
184													
185	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>												
186	<b>Cost Center Information</b>												
187	<b>Expenditure Information</b>												
188	<b>Adjustment / Transfer</b>												
189	Trial Balance Account Number	Account Description	TOTAL Amount to be Transferred to Trial Balance	Enter Amount of Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5				
190		39500 Depreciation Expense					\$0.00	Select from Dropdown Menu	Select from Dropdown Menu				
191							\$0.00						
192			\$0.00	\$0.00	\$0.00	\$0.00	\$0.00						
193													
194													

1	North Carolina Division of Medical Assistance												
2	Local Health Department Cost Report												
3	Non-Reimbursable Expenditures												
4	0												
5	Complete Shaded Areas Only												
6													
7	All Expenditures Come from Audited Financial Statements												
8													
9	Period for Expenditures:												
10	Fiscal Year Start Date	7/1/2016	Primary NPI Number	0									
11	Fiscal Year End Date	6/30/2017	Medicaid Provider Number	0									
12													

**SECTION I. Personnel / Staff Expenditures**

**Personnel Cost Center Information**

Cost Center Name					Salary and Benefits										
510XX Non Clinical/Medical Personnel Cost (Environmental Health, Home Health, Bioterrorism, etc)					Total Gross Salary	51000	Employee Benefits	51010	Employer- FICA (if not covered under employee benefits)	51015	Medicare Tax -Employer - (if not listed under employee benefits)	51020	Other Benefits / Vendor or Contractor Payments	51025	TOTAL SALARY AND BENEFITS
Trial Balance Amount (From Financial Statements)														\$0.00	
Reductions to Trial Balance															
Personnel Information					Salary and Benefit Reductions - Salary and Benefits to be Removed from Cost Center										
Position Number / Employee ID	Last Name	First Name	Job Title	Vendor/ Employee	Is position funded by Federal funds? Yes or No	Enter Amount of Salary to be Removed from Cost Center	Enter Amount of Benefits to be Removed from Cost Center	Enter Amount of Employer - FICA to be Removed from Cost Center	Enter Amount of Medicare Tax to be Removed from Cost Center	Enter Amount of Other Benefits to be Removed from Cost Center	Total Reduction to Salary and Benefits				
														\$0.00	
														\$0.00	
														\$0.00	
														\$0.00	
TOTAL REDUCTIONS						\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00				

**SECTION II. Non-Reimbursable Expenditures**

**Operating Cost Center Information**

Expenditure Information			Total Expenditure	Expenditure Reductions - Amount to be Removed from Cost Center					Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5
Trial Balance Account Number	Account Description	Total Trial Balance Amount	Enter Amount of Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Select from Dropdown Menu		Select from Dropdown Menu	
51100	Environmental Health					\$0.00				
51200	Home Health					\$0.00				
51300	CC4C (Community Care 4 Child)					\$0.00				
51400	PCM (Pregnancy Case Management)					\$0.00				
51500	WIC (Women Infant Children)					\$0.00				
55000	Capital Expenditures					\$0.00				
51600	Reference Lab					\$0.00				
51700	Other Non-Reimbursable Expenditures					\$0.00				
TOTAL			\$0.00	\$0.00	\$0.00	\$0.00				

**SECTION III. Adjustments/Transfers to Trial Balance**

**Cost Center Information**

Expenditure Information			Adjustment / Transfer	Expenditure Reductions - Amount to be Removed from Cost Center					Identify COST CENTER Where Reduction Amount Will Be Moved	Identify ACCOUNT Detail Where Reduction Will Appear for Exhibit 5
Trial Balance Account Number	Account Description	TOTAL Amount to be Transferred to Trial Balance	Enter Amount of Expenditure to be Removed from Cost Center	Add: State/Local Match required for Federal Funds	Other amounts to be removed	TOTAL Amount to be Reduced from Cost Center	Select from Dropdown Menu		Select from Dropdown Menu	
59500	Depreciation Expense - Non-Reimbursable					\$0.00				
TOTAL			\$0.00	\$0.00	\$0.00	\$0.00				

	E	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S			
2	North Carolina Division of Medical Assistance																				
3	Local Health Department Cost Report																				
4	0																				
6	Total Expenditure by Classification (Expenditure Summary)																				
8	<b>DO NOT ENTER ANY INFORMATION ON FORM</b>																				
10	Period for Expenditures																				
11	Fiscal Year Start Date			7/1/2016			Primary NPI Number			0											
12	Fiscal Year End Date			6/30/2017			Medicaid Provider Number			0											
14	TOTAL EXPENDITURES			Reference			(1) Salary & Wages			(2) Employee Benefits			(3) Payroll Taxes			(4) Other Comp.			(5) Subtotal Expenditures		
15	<b>LHD Administration / Support Costs by Discipline</b>																				
16	<b>SECTION I. Personnel / Staff Expenditures</b>																				
17	110XX Health Director's Office and Staff			0.00			0.00			0.00			0.00			0.00					
18	120XX Finance Office and Staff			0.00			0.00			0.00			0.00			0.00					
19	130XX Other Personnel			0.00			0.00			0.00			0.00			0.00					
20	TOTAL (From Exhibit 4a, Section I)			0.00			0.00			0.00			0.00			0.00					
22	<b>SECTION II. Operating Expenditures</b>																				
23	14800 Supplies - LHD Admin / Support															0.00					
24	15000 Capital Expenditures - LHD Admin / Support															0.00					
25	16000 Contracted Services - LHD Admin / Support															0.00					
26	17000 Other Operating Expenditures - LHD Admin / Support															0.00					
27	TOTAL (From Exhibit 4a, Section II)															0.00					
29	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>																				
30	18500 Depreciation Expense - LHD Admin / Support															0.00					
31	18600 Indirect Costs from CAP															0.00					
32	TOTAL (From Exhibit 4a, Section III)															0.00					
34	<b>Clinical Administration / Support Costs by Discipline</b>																				
35	<b>SECTION I. Personnel / Staff Expenditures</b>																				
36	210XX Nursing Director's Office and Clinical Supervisor Staff			0.00			0.00			0.00			0.00			0.00					
37	220XX Billing Office and Staff			0.00			0.00			0.00			0.00			0.00					
38	230XX Interpreters			0.00			0.00			0.00			0.00			0.00					
39	240XX Other Personnel			0.00			0.00			0.00			0.00			0.00					
40	TOTAL (From Exhibit 4b, Section I)			0.00			0.00			0.00			0.00			0.00					
42	<b>SECTION II. Operating Expenditures</b>																				
43	24800 Supplies - Clinic Admin															0.00					
44	25000 Capital Expenditures - Clinic Admin															0.00					
45	26000 Contracted Services - Clinic Admin															0.00					
46	27000 Other Operating Expenditures - Clinic Admin															0.00					
47	TOTAL (From Exhibit 4b, Section II)															0.00					
49	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>																				
50	29500 Depreciation Expense															0.00					
51	TOTAL (From Exhibit 4b, Section III)															0.00					
53	<b>Direct Medical / Clinic Costs by Discipline</b>																				
54	<b>SECTION I. Personnel / Staff Expenditures</b>																				
55	310XX - Physicians (MD, PA, Nurse Practitioner)			0.00			0.00			0.00			0.00			0.00					
56	320XX Nurses (PHN, RN, Enhanced Role Nurse)			0.00			0.00			0.00			0.00			0.00					
57	330XX Social Workers			0.00			0.00			0.00			0.00			0.00					
58	340XX Health Educators & Nutritionists			0.00			0.00			0.00			0.00			0.00					
59	341XX Laboratory Staff (Techs, etc.)			0.00			0.00			0.00			0.00			0.00					
60	342XX Other Medical / Clinic Personnel			0.00			0.00			0.00			0.00			0.00					
61	TOTAL (From Exhibit 4c, Section I)			0.00			0.00			0.00			0.00			0.00					
63	<b>SECTION II. Operating Expenditures</b>																				
64	34800 Supplies - Medical / Clinic															0.00					
65	35000 Capital Expenditures - Medical / Clinic															0.00					
66	36000 Contracted Services - Medical / Clinic															0.00					
67	36900 Laboratory Expenditures															0.00					
68	37000 Other Operating Expenditures - Medical / Clinic															0.00					
69	TOTAL (From Exhibit 4c, Section II)															0.00					
71	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>																				
72	39500 Depreciation Expense															0.00					
73	TOTAL (From Exhibit 4c, Section III)															0.00					
75	<b>Non-Reimbursable Expenditures</b>																				
76	<b>SECTION I. Personnel / Staff Expenditures</b>																				
77	510XX Non Clinical/Medical Personnel Cost (Environmental Health, Home Hea			0.00			0.00			0.00			0.00			0.00					
78	TOTAL (From Exhibit 4d, Section I)			0.00			0.00			0.00			0.00			0.00					
80	<b>SECTION II. Non-Reimbursable Expenditures</b>																				
81	51100 Environmental Health															0.00					
82	51200 Home Health															0.00					
83	51300 CC4C (Community Care 4 Child)															0.00					
84	51400 PCM (Pregnancy Case Management)															0.00					
85	51500 WIC (Women Infant Children)															0.00					
86	55000 Capital Expenditures															0.00					
87	51600 Reference Lab															0.00					
88	51700 Other Non-Reimbursable Expenditures															0.00					
89	TOTAL (From Exhibit 4d, Section II)															0.00					
91	<b>SECTION III. Adjustments/Transfers to Trial Balance</b>																				
92	59500 Depreciation Expense - Non-Reimbursable															0.00					
93	TOTAL (From Exhibit 4d, Section III)															0.00					
95	TOTAL COST			0.00			0.00			0.00			0.00			0.00					



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**North Carolina Division of Medical Assistance  
Local Health Department Cost Report**

**0  
Allocations**

**DO NOT ENTER ANY INFORMATION ON FORM**

**Period for Expenditures**

Fiscal Year Start Date: 7/1/2016  
Fiscal Year End Date: 6/30/2017

Primary NPI Number: 0  
Medicaid Provider Number: 0

- Allocations:**  
 1 To Nursing Cost Pool  
 2 To Social Worker Cost Pool  
 3 To Health Educator / Nutritionist Cost Pool  
 4 To Allocated Administration/Support Cost Pools  
 5 To Allocated Clinical Admin Cost Pool  
 6 To Direct Medical Cost Pool  
 7 To Laboratory Services Cost Pool (Non-Reimbursable Cost Pool)  
 8 To Non-Reimbursable Cost Pool

	(1) Total Expenditure	(2) Allocation	(3) Nursing Cost Pool	(4) Social Worker Cost Pool	(5) Health Educator & Nutritionist Cost Pool	(6) Allocated Admin Support Cost Pool	(7) Allocated Clinical Admin Cost Pool	(8) Direct Medical Cost Pool	(9) Laboratory Services Cost Pool	(10) Non-Reimbursable Cost Pool
<b>21 TOTAL EXPENDITURES</b> Reference										
<b>22 LHD Administration / Support Costs by Discipline</b>										
<b>23 SECTION I. Personnel / Staff Expenditures</b>										
24 110XX Health Director's Office and Staff	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
25 120XX Finance Office and Staff	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
26 130XX Other Personnel	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
27 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>29 SECTION II. Operating Expenditures</b>										
30 14800 Supplies - LHD Admin / Support	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
31 15000 Capital Expenditures - LHD Admin / Support	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
32 16000 Contracted Services - LHD Admin / Support	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
33 17000 Other Operating Expenditures - LHD Admin / Support	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
34 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>36 SECTION III. Adjustments/Transfers to Trial Balance</b>										
37 18500 Depreciation Expense - LHD Admin / Support	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
38 18600 Indirect Costs from CAP	\$0.00	4	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
39 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>41 Clinical Administration / Support Costs by Discipline</b>										
<b>42 SECTION I. Personnel / Staff Expenditures</b>										
43 210XX Nursing Director's Office and Clinical Supervisor Staff	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
44 220XX Billing Office and Staff	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
45 230XX Interpreters	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
46 240XX Other Personnel	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
47 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>49 SECTION II. Operating Expenditures</b>										
50 24800 Supplies - Clinic Admin	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51 25000 Capital Expenditures - Clinic Admin	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
52 26000 Contracted Services - Clinic Admin	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
53 27000 Other Operating Expenditures - Clinic Admin	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
54 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>56 SECTION III. Adjustments/Transfers to Trial Balance</b>										
57 29500 Depreciation Expense	\$0.00	5	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
58 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
<b>60 Direct Medical / Clinic Costs by Discipline</b>										
<b>61 SECTION I. Personnel / Staff Expenditures</b>										
62 310XX - Physicians (MD, PA, Nurse Practitioner)	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
63 320XX Nurses (PHN, RN, Enhanced Role Nurse)	\$0.00	1	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
64 330XX Social Workers	\$0.00	2	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
65 340XX Health Educators & Nutritionists	\$0.00	3	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
66 341XX Laboratory Staff (Techs, etc.)	\$0.00	7	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
67 342XX Other Medical / Clinic Personnel	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
68 <b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**North Carolina Division of Medical Assistance  
Local Health Department Cost Report**

**0  
Allocations**

**DO NOT ENTER ANY INFORMATION ON FORM**

**Period for Expenditures**

Fiscal Year Start Date: 7/1/2016  
Fiscal Year End Date: 6/30/2017

Primary NPI Number: 0  
Medicaid Provider Number: 0

**SECTION II. Operating Expenditures**

34800 Supplies - Medical / Clinic	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
35000 Capital Expenditures - Medical / Clinic	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
36000 Contracted Services - Medical / Clinic	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
36900 Laboratory Expenditures	\$0.00	7	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
37000 Other Operating Expenditures - Medical / Clinic	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**SECTION III. Adjustments/Transfers to Trial Balance**

39500 Depreciation Expense	\$0.00	6	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**Non-Reimbursable Expenditures**

**SECTION I. Personnel / Staff Expenditures**

510XX Non Clinical/Medical Personnel Cost (Environmental Health)	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**SECTION II. Non-Reimbursable Expenditures**

51100 Environmental Health	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51200 Home Health	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51300 CC4C (Community Care 4 Child)	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51400 PCM (Pregnancy Case Management)	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51500 WIC (Women Infant Children)	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
55000 Capital Expenditures	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51600 Reference Lab	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
51700 Other Non-Reimbursable Expenditures	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**SECTION III. Adjustments/Transfers to Trial Balance**

59500 Depreciation Expense - Non-Reimbursable	\$0.00	8	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
<b>TOTAL (From Exhibit 5)</b>	<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>

**TOTAL COST**

<b>\$0.00</b>		<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>	<b>\$0.00</b>
---------------	--	---------------	---------------	---------------	---------------	---------------	---------------	---------------	---------------	---------------	---------------

**LOCAL HEALTH DEPARTMENT CALCULATED COST POOLS**

Subtotal Nursing Cost Pool	\$ -
Subtotal Social Worker Cost Pool	\$ -
Subtotal Health Educator & Nutritionist Cost Pool	\$ -
Subtotal Allocated Admin Support Cost Pool	\$ -
Subtotal Allocated Clinical Admin Cost Pool	\$ -
Subtotal Direct Medical Cost Pool	\$ -
Subtotal Laboratory Cost Pool (Non-Reimbursable Cost Pool)	\$ -
Subtotal Non-Reimbursable Cost Pool	\$ -
<b>TOTAL EXPENDITURES</b>	<b>\$ -</b>

Admin Support Cost Pool Allocated in Section 1. Below

Clinical Admin Support Cost Pool Allocated in Section 2. Below

	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD
2	<b>North Carolina Division of Medical Assistance</b>																												
3	<b>Local Health Department Cost Report</b>																												
4	<b>0</b>																												
5	<b>Allocations</b>																												
6	<b>DO NOT ENTER ANY INFORMATION ON FORM</b>																												
8	<b>Period for Expenditures</b>																												
9	Fiscal Year Start Date			7/1/2016			Primary NPI Number			0																			
10	Fiscal Year End Date			6/30/2017			Medicaid Provider Number			0																			
126	<b>Allocation #1 - Allocating the Allocated Admin Support Cost Pool</b>																												
127	Costs will be allocated to all cost pools using Accumulated Cost																												
128	<b>LOCAL HEALTH DEPARTMENT ADJUSTED COST POOLS</b>															Amt. From Calculated Expenditures	Amt. From Allocated Admin Support Cost Pool (Calculated Using Accumulated Cost)	<b>Total Adjusted Amount</b>	<b>Admin Support Allocation Formula used in Column Q, Rows 130, 132, 134, 136, 138, 140, 142</b>										
130	Adjusted Nursing Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Nursing Cost Pool Exhibit 6 Cell O130 / (Total Expenditures Exhibit 6 Cell O144))										
132	Adjusted Social Worker Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Social Worker Cost Pool Exhibit 6 Cell O132 / (Total Expenditures Exhibit 6 Cell O144))										
134	Total Adjusted Health Educator & Nutritionist Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Health Educator & Nutritionist Cost Pool Exhibit 6 Cell O134 / (Total Expenditures Exhibit 6 Cell O144))										
136	Total Adjusted Allocated Clinical Admin Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Clinical Admin Cost Pool Exhibit 6 Cell O136 / (Total Expenditures Exhibit 6 Cell O144))										
138	Total Adjusted Direct Medical Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Direct Medical Cost Pool Exhibit 6 Cell O138 / (Total Expenditures Exhibit 6 Cell O144))										
140	Total Adjusted Laboratory Cost Pool (Non-Reimbursable Cost Pool)															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Laboratory Cost Pool Exhibit 6 Cell O140 / (Total Expenditures Exhibit 6 Cell O144))										
142	Total Adjusted Non-Reimbursable Cost Pool															\$ -	#DIV/0!	#DIV/0!	(Admin Support Exhibit 6 Cell O114) X (Adjusted Non-Reimbursable Cost Pool Exhibit 6 Cell O142 / (Total Expenditures Exhibit 6 Cell O144))										
144	Total Expenditures															\$ -	#DIV/0!	#DIV/0!											
146	<b>Allocation #2 - Allocating the Allocated Clinical Admin Cost Pool</b>																												
147	Costs will be allocated to all cost pools using Total Salaries and Benefits Costs																												
148	<b>LOCAL HEALTH DEPARTMENT ADJUSTED COST POOLS</b>															Amt. From Allocation #1	Amt. From Allocated Clinical Admin Cost Pool (Calculated Using Accumulated Cost)	<b>Total Adjusted Amount</b>	<b>Clinical Admin Support Allocation Formula Used in Column Q Rows 150, 152, 154, 156, 158</b>										
150	Total Adjusted Nursing Cost Pool															#DIV/0!	#DIV/0!	#DIV/0!	(Total Adjusted Clinical Admin Support Cost Pool Cell S136) X (Total Adjusted Nursing Cost Pool Cell O150 / (Total Expenditures Cell O162 - Total Adjusted Non-Reimbursable Cost Pool Cell O160))										
152	Total Adjusted Social Worker Cost Pool															#DIV/0!	#DIV/0!	#DIV/0!	(Total Adjusted Clinical Admin Support Cost Pool Cell S136) X (Total Adjusted Social Worker Cost Pool Cell O152 / (Total Expenditures Cell O162 - Total Adjusted Non-Reimbursable Cost Pool Cell O160))										
154	Total Adjusted Health Educator & Nutritionist Cost Pool															#DIV/0!	#DIV/0!	#DIV/0!	(Total Adjusted Clinical Admin Support Cost Pool Cell S136) X (Total Adjusted Health Educator & Nutritionist Cost Pool Cell O154 / (Total Expenditures Cell O162 - Total Adjusted Non-Reimbursable Cost Pool Cell O160))										
156	Total Adjusted Direct Medical Cost Pool															#DIV/0!	#DIV/0!	#DIV/0!	(Total Adjusted Clinical Admin Support Cost Pool Cell S136) X (Total Adjusted Direct Medical Cost Pool Cell O156 / (Total Expenditures Cell O162 - Total Adjusted Non-Reimbursable Cost Pool Cell O160))										
158	Total Adjusted Laboratory Cost Pool (Non-Reimbursable Cost Pool)															#DIV/0!	#DIV/0!	#DIV/0!	(Total Adjusted Clinical Admin Support Cost Pool Cell S136) X (Total Adjusted Laboratory Cost Pool Cell O158 / (Total Expenditures Cell O162 - Total Adjusted Non-Reimbursable Cost Pool Cell O160))										
160	Total Adjusted Non-Reimbursable Cost Pool															#DIV/0!	#DIV/0!	#DIV/0!											
162	Total Expenditures															#DIV/0!	#DIV/0!	#DIV/0!											

	A	B	C	D	E	F	G	H
1								
2		<b>North Carolina Division of Medical Assistance</b>						
3		<b>Local Health Department Cost Report</b>						
4		<b>Expenditures for Settlement</b>						
5		<b>0</b>						
6		<b>DO NOT ENTER ANY INFORMATION ON FORM</b>						
7								
8								
9		<b>Period for Expenditures</b>						
10		Fiscal Year Start Date	7/1/2016	Primary NPI Number	0			
11		Fiscal Year End Date	6/30/2017	Medicaid Provider Number	0			
12								
13								
14								
15		<b>Nursing Cost Pool for Settlement</b>						
16								
17								
18								
19								
20		<b>Cost Pool</b>	Total Adjusted Expenditures from Allocation	Apply Direct Medical Time Study Alloc. % from Actual Time Results	Apply Medicaid Administrative Time Study Alloc. % from Actual Time Results MEDICAID COSTS (Medicaid Utilization Already Applied)	Non-Reimbursable Costs	Total Expenditures	
21				0.00%	0.00%	100.00%		
22								
23		<b>Nurses</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
24								
25								
26		<b>Total - All Disciplines</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
27								
28								
29								
30		<b>Social Worker Cost Pool for Settlement</b>						
31								
32								
33								
34								
35		<b>Cost Pool</b>	Total Adjusted Expenditures from Allocation	Apply Direct Medical Time Study Alloc. % from Actual Time Results	Apply Medicaid Administrative Time Study Alloc. % from Actual Time Results MEDICAID COSTS (Medicaid Utilization Already Applied)	Non-Reimbursable Costs	Total Expenditures	
36				0.00%	0.00%	100.00%		
37								
38		<b>Social Workers</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
39								
40								
41		<b>Total - All Disciplines</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
42								
43								
44		<b>Health Educator &amp; Nutritionist Cost Pool for Settlement</b>						
45								
46								
47								
48								
49		<b>Cost Pool</b>	Total Adjusted Expenditures from Allocation	Apply Direct Medical Time Study Alloc. % from Actual Time Results	Apply Medicaid Administrative Time Study Alloc. % from Actual Time Results MEDICAID COSTS (Medicaid Utilization Already Applied)	Non-Reimbursable Costs	Total Expenditures	
50				0.00%	0.00%	100.00%		
51								
52		<b>Health Educators &amp; Nutritionists</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
53								
54								
55		<b>Total - All Disciplines</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
56								
57								
58		<b>Direct Medical Costs Pool for Settlement (Physicians / Physicians Assistance/Nurse Practitioner/Nurse Midwife)</b>						
59								
60								
61								
62								
63		<b>Cost Pool</b>	Total Adjusted Expenditures from Allocation	N/A (Apply Direct Medical Percentage from Actual Time Results) - 100%	N/A (Apply Medicaid Administrative Time Study Alloc. % from Actual Time Results MEDICAID COSTS (Medicaid Utilization Already Applied))	N/A Non-Reimbursable Costs	Total Expenditures	
64				100.00%	0.00%	0.00%		
65								
66		<b>Direct Medical</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
67								
68								
69		<b>Total - All Disciplines</b>	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
70								
71								

	A	B	C	D	E	F	G	H
1								
2		<b>North Carolina Division of Medical Assistance</b>						
3		<b>Local Health Department Cost Report</b>						
4		<b>Payments</b>						
5		<b>0</b>						
6		<b>Complete Shaded Areas Only</b>	Primary NPI Number	0				
7			Medicaid Provider Number	0				
8								
9		<b>Period for Transactions</b>						
10		Fiscal Year Start Date	7/1/2016					
11		Fiscal Year End Date	6/30/2017					
12								
13								
14		<b>Section I. Payments and Transactions</b>						
15								
16		<b>Description of Payment/Transaction</b>	<b>Total Amount</b>	<b>MEDICAID CLINIC SERVICES RELATED</b>	<b>MEDICAID FAMILY PLANNING SERVICES RELATED</b>	<b>MEDICAID ADMINISTRATIVE CLAIMING RELATED</b>	<b>NC HEALTH CHOICE SERVICES</b>	
17		Medicaid Interim Payments - Clinic Services	\$0					
18		Medicaid Interim Payments - Family Planning	\$0					
19		MAC Payment - Q1	\$0					
20		MAC Payment - Q2	\$0					
21		MAC Payment - Q3	\$0					
22		MAC Payment - Q4	\$0					
23		NC Health Choice Services - Interim Claim Payments	\$0					
24		<b>Total - All Disciplines</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>	<b>\$0</b>
25								
26								

1	North Carolina Division of Medical Assistance									
2	Local Health Department Cost Report									
3	Direct Medical Costs for Settlement									
4	0									
5	Complete Shaded Areas Only							Primary NPI Number	0	
6								Medicaid Provider Number	0	
7										
8	Period for Expenditures and Payments									
9	Fiscal Year Start Date		7/1/2016							
10	Fiscal Year End Date		6/30/2017							
11										

12	Direct Medical Settlement									
13		From Exhibit 7	Col. C * Col. D %	Col. D * Col. E %	Col. D * Col. F %	Col. D * Col. G %	Col. C * Col. H %	Sum Cols. E- H		
14			MEDICAID COSTS Apply Medicaid Utilization % from Exhibit 2-Statistical Information	MEDICAID CLINIC SERVICES COSTS Apply Medicaid Clinical Charges % From Exhibit 2- Statistical Information	MEDICAID FAMILY PLANNING COSTS Apply Medicaid Family Planning Paid Claims % From Exhibit 2-Statistical Information	MEDICAID FAMILY PLANNING WAIVER COSTS - Non- Reimbursable Apply Medicaid FP Waiver Charges % From Exhibit 2- Statistical Information	NC HEALTH CHOICE COSTS Apply NC Health Choice Utilization % from Exhibit 2- Statistical Information		Medicaid and Health Choice Total Expenditures	
15	I. Direct Medical Costs	Total Expenditures	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		
16	Costs									
17	Nurses	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
18	Social Workers	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
19	Health Educators & Nutritionists	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
20	Direct Medical	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
21										
22	Total - All Disciplines	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
23										
24		From Exhibit 6	Col. C * Col. D %	Col. D * Col. E %	Col. D * Col. F %	Col. D * Col. G %	Col. C * Col. D %			
25		Total Expenditures	Medicaid Costs	Medicaid Clinic Services Cost	Medicaid Family Planning Services Cost	Medicaid Famil Planning Waiver Costs	NC Health Choice Costs			
26	Laboratory Service Costs	#DIV/0!	#DIV/0!				#DIV/0!			
27	Laboratory Medicare Fee Schedule Rate									
28	Lesser of Lab Service Costs or Medicare Fee Schedule		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
29										
30	Total Direct Medical Costs Plus Lab Costs			#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
31	TOTAL MEDICAID / HEALTH CHOICE INTERIM PAYMENTS (From Exhibit 8)			\$0	\$0	NA	\$0			
32	NET MEDICAID / HEALTH CHOICE COMPUTABLE COSTS			#DIV/0!	#DIV/0!	NA	#DIV/0!			
33				FMAP (Blended)	66.72%	90.00%	NA	99.71%		
34				NET SETTLEMENT AMOUNT	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		

"When the provider files a cost report indicating that an overpayment has occurred, full refund is to be remitted with the cost report." CMS Publication 15-1, Section 2409.1(A)(2)

**\*\*\* IMPORTANT NOTE\*\*\* Medicaid and NCHC are derived from separate funding sources; therefore, any Medicaid and NC Health Choice settlements which are identified as payables or receivables shall not be combined or netted. The settlements for Medicaid and NC Health Choice must be executed as separate and distinct transactions. If the provider has payables due the Program(s) for both Medicaid and NC Health Choice, the provider shall submit separate remittances. Providers shall enclose a copy of the Exhibit 9a showing the Medicaid and NC Health Choice settlement with the appropriate corresponding remittance so that payments can be properly posted as Medicaid or NC Health Choice.**

Any return of overpament shall be remitted under a separate cover with a copy of Exhibit 9a to:

DHHS Accounts Receivable  
 Division of Medical Assistance  
 2022 Mail Service Center  
 Raleigh, North Carolina 27699-2022

	A	B	C	D
1	<b>North Carolina Division of Medical Assistance</b>			
2	<b>Local Health Department Cost Report</b>			
3	<b>Medicaid Administrative Claiming Costs for Settlement</b>			
4	<b>0</b>			
5	<b>DO NOT ENTER ANY INFORMATION ON FORM</b>		Primary NPI Number	0
6			Medicaid Provider Number	0
7				
8	<b>Period for Expenditures and Payments</b>			
9			Fiscal Year Start Date	7/1/2016
10			Fiscal Year End Date	6/30/2017
11				
12	<b>Medicaid Administrative Claiming Settlement</b>			
13				
14				
15				
16	<b>I. Medicaid Administrative Costs</b>		<b>MEDICAID ADMINISTRATIVE CLAIMING COSTS</b> From Exhibit 7	
17				
18	Nurses		#DIV/0!	
19	Social Workers		#DIV/0!	
20	Health Educators & Nutritionists		#DIV/0!	
21	Direct Medical (Physicians/Billing/Intake)		#DIV/0!	
22				
23	<b>COMPUTABLE MEDICAID ADMINISTRATIVE COSTS</b>		<b>#DIV/0!</b>	
24	<b>FFP</b>		<b>50.00%</b>	
25	<b>MEDICAID ADMINISTRATIVE CLAIMING AMOUNT</b>		<b>#DIV/0!</b>	
26	<b>TOTAL MEDICAID MAC PAYMENTS FOR FISCAL YEAR (From Exhibit 8)</b>		<b>\$0.00</b>	
27	<b>NET MEDICAID SETTLEMENT AMOUNT</b>		<b>#DIV/0!</b>	
28				



	A	B	C	D	E	F	G
1	<b>North Carolina Division of Medical Assistance</b>						
2	<b>Local Health Department Cost Report</b>						
3	<b>Financial Report Summary</b>						
4	<b>0</b>						
5	<b>Complete Shaded Areas Only</b>				Primary NPI Number		0
6					Medicaid Provider Number		0
7							
8	<b>Period for Expenditures</b>						
9	Fiscal Year Start Date		7/1/2016				
10	Fiscal Year End Date		6/30/2017				
11							
12	<b>LHD FINANCIAL SUMMARY</b>						
13							
14	<b>*Please see accompanying audited financial report for more information.</b>						
15							
16	Gross Expenditures from LHD Financials						
17							
18	Adjustments						
19	Depreciation						
20	Indirect Costs						
21	Other						
22	<b>Net Expenditures from Financials</b>					<b>\$0.00</b>	
23							
24	<b>Total Expenditures per Cost Report (From Exhibit 5)</b>					<b>\$0.00</b>	
25							
26	<b>Variance</b>					<b>\$0.00</b>	
27							

	A	B	C	D	E
1	<b>North Carolina Division of Medical Assistance</b>				
2	<b>Local Health Department Cost Report</b>				
3	<b>0</b>				
4	<b>Variance Report - QC</b>				
5	<b>DO NOT ENTER ANY INFORMATION ON FORM</b>			Primary NPI Number	0
6				Medicaid Provider Number	0
7					
8	<b>Period for Expenditures and Payments</b>				
9				Fiscal Year Start Date	7/1/2016
10				Fiscal Year End Date	6/30/2017
11					
12	<b>Differences Between Exhibits - ALL DIFFERENCES SHOULD EQUAL \$0</b>				
13					
14					
15	<b>Total Expenditure Comparison - Exhibit 5 vs. LHD Financials</b>	<b>Exhibit 5 Total Expenditures</b>	<b>LHD Financials (Exhibit 10)</b>	<b>Diff</b>	
16	Total Expenditures	\$0.00	\$0.00	\$0.00	
17					
18	<b>Administration and Support Comparison - Exhibits 5 vs. 4a</b>	<b>Total Expenditures Exhibit 5</b>	<b>Total Expenditures Exhibit 4a</b>	<b>Diff</b>	
19	Total Expenditures	\$0.00	\$0.00	\$0.00	
20					
21	<b>Clinical Administration Comparison - Exhibits 5 vs. 4b</b>	<b>Total Expenditures Exhibit 5</b>	<b>Total Expenditures Exhibit 4b</b>	<b>Diff</b>	
22	Total Expenditures	\$0.00	\$0.00	\$0.00	
23					
24	<b>Direct Medical Comparison - Exhibits 5 vs. 4c</b>	<b>Total Expenditures Exhibit 5</b>	<b>Total Expenditures Exhibit 4c</b>	<b>Diff</b>	
25	Total Expenditures	\$0.00	\$0.00	\$0.00	
26					
27	<b>Non-Reimbursable Comparison - Exhibits 5 vs. 4d</b>	<b>Total Expenditures Exhibit 5</b>	<b>Total Expenditures Exhibit 4d</b>	<b>Diff</b>	
28	Total Expenditures	\$0.00	\$0.00	\$0.00	
29					
30	<b>Adjustments / Transfers to Trial Balance Comparison - Exhibits 5 vs. LHD Financials</b>	<b>Adjustments/Transfers Exhibit 5</b>	<b>LHD Financials Exhibit 10</b>	<b>Diff</b>	
31	Total Reclassifications	\$0.00	\$0.00	\$0.00	
32					
33	<b>Allocations and Total Expenditures Comparison - Exhibits 5 vs. 6</b>	<b>Total Expenditures Exhibit 5</b>	<b>Total Expenditures Exhibit 6</b>	<b>Diff</b>	
34	Total Expenditures	\$0.00	\$0.00	\$0.00	
35					
36	<b>Total Allocated Expenditures and Settlement Cost Comparison - Exhibits 6 vs. 7</b>	<b>Total Allocated Adj. Expenditures - Exhibit 6</b>	<b>Total Expenditures for Settlement - Exhibit 7</b>	<b>Diff</b>	
37	Nurses Cost Pool	#DIV/O!	#DIV/O!	#DIV/O!	
38	Social Worker Cost Pool	#DIV/O!	#DIV/O!	#DIV/O!	
39	Health Educator & Nutritionist Cost Pool	#DIV/O!	#DIV/O!	#DIV/O!	
40	Direct Medical Cost Pool	#DIV/O!	#DIV/O!	#DIV/O!	
41					
42	<b>Summary Settlement Comparison - Exhibits 1a vs. 9a, 9b, 9c</b>	<b>Summary of Settlement Amounts - Exhibit 1a</b>	<b>Total Calculated Summary - Exhibits 9a-c</b>	<b>Diff</b>	
43	Medical Settlement	#DIV/O!	#DIV/O!	#DIV/O!	
44	Family Planning Settlement	#DIV/O!	#DIV/O!	#DIV/O!	
45	NC Health Choice Settlement	#DIV/O!	#DIV/O!	#DIV/O!	
46	Medicaid Administrative Claiming Settlement	\$0.00	#DIV/O!	#DIV/O!	
47					
48	<b>Summary Expenditure Comparison - Exhibits 1c and 5</b>	<b>Total on Cover - Exhibit 1c</b>	<b>Total Expenditures - Exhibit 5</b>	<b>Diff</b>	
49	Admin Support	\$0.00	\$0.00	\$0.00	
50	Medical Support	\$0.00	\$0.00	\$0.00	
51	Direct Medical	\$0.00	\$0.00	\$0.00	
52	Non Reimbursable	\$0.00	\$0.00	\$0.00	
53	Total Expenditure	\$0.00	\$0.00	\$0.00	
54					
55					
56					