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

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2017 FEDERALLY QUALIFIED HEALTH CENTER

1. Name and Address					
Name of Facility:					
Street or P.O. Box:					
City:		State:		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:				Name:			
Address:				Address:			
City:				City:			
State:		Zip:		State:		Zip:	
Contact Name:							
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.	COST OF MEDICAID CORE SERVICES 2017 COST REPORT	Reporting Period From: To:

	(1)
1. Cost per Covered Visit (CMS Form 224-14, W/S B, Part 1, Line 13, Col. 6)	
2. Medicaid Covered Visits for Core Services (From Provider Records) Including Mental Health Services	
3. Medicaid Cost for Core Services (Line 1 x 2)	

DMA-FQHC (06/2016)
Audit Section

RUN DATE: 8/15/17

NPI NO. PROVIDER NO.	COST OF OTHER AMBULATORY SERVICES 2017 COST REPORT	Reporting Period From: To:

1. Cost for Other FQHC Services - (Sum of Lines 1a - 1g) (Figures are from CMS Form 224-14, W/S A, Column 7, Lines 60-69 + Line 77)	
a. Dental	
b. Health Check Services (formerly EPSDT)	
c. Radiology Services (on-site)	
d. Norplant Services	
e. Physician Hospital Services	
f. Pharmacy (See Cost Report Instructions)	
g. Other	
2. Cost of All Services - excluding overhead (CMS Form 224-14, W/S A, Col 7, Line 100- Line 13 + Line 9)	
3. Percentage of Other FQHC Services (Line 1 / 2)	
4. Net Facility Overhead (CMS Form 224-14, W/S A, Col 7, Line 13 - Line 9).	
5. Overhead Cost Applicable to Other FQHC Services (Line 3 x 4)	

RUN DATE: 8/15/17

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

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

** Encounter

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

(1)	Cost Per Encounter DMA-3 (2)	Medicaid Encounters (From Provider Records) (3)	Medicaid Cost (Col 2 x 3) (4)	
1. FQHC Services				
a. Dental				
b. Health Check Services (Formerly EPSDT)				
c. Radiology Services (on-site)				
d. Norplant Services				
e. Physician Hospital Services				
f. Pharmacy				
g. Other (Specify)				
2. Subtotal				
3. Less: Physician Hospital Services				
4. Total Ambulatory Services (Line 2 - 3)				
5. Medicaid Core Service Cost				(DMA-1, Line 3)
6. Medicaid Cost of Pneumococcal and Influenza Vaccine				(DMA-7, Line 4)
7. Medicaid Cost of Allowable Graduate Medical Education Pass Through				(DMA-8, Line 5)
8. Total Reimbursable Cost (Lines 4 + 5 + 6+ 7)				
9. Amount Received/Receivable from Medicaid (From Provider Records)				(DMA-5, Line 6)
10. Amount Due Provider <Program> Exclusive of Bad Debts (Line 8 - Line 9)				
11. Adjusted Reimbursable Bad Debts				(DMA-6, Line 6)
12. Total Amount Due Provider <Program> (Line 9 + Line 10)				

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

(1)	Amount * (From Provider Records) (2)	Provider Number/s (3)	
1. FQHC Payments			
***a**. Dental			
b. Health Check Services (formerly EPSDT) .			
***c**. Radiology Services (on-site).			
d. Norplant Services			
e. Physician Hospital Services			
f. Pharmacy			
g. Other (Other, etc.)			
2. Core Services			
3. Third Party Liability			
4. Subtotal (Lines 1 through 3).			
5. Less: Physician Hospital Services			
6. Total Medicaid Payments (Line 4 -5)			(DMA-4, Line 9)

*** Note:** Co-pay not applicable to Core Services.
Co-pay is applicable to Ambulatory Services.
Carolina Access payments are not to be included.
Medicaid crossover payments are not to be included.

Comments:

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

(1)	Amount (2)	
1. Co-Payment Billed to Medicaid Patients (From Provider Records)		
2. Co-Payment Amounts Received From Medicaid Patients (From Provider Records)		
3. Medicaid Bad Debts (Line 1 - 2)		
4. Less Medicaid Bad Debt Recoveries (From Provider Records)		
5. Allowable Bad Debts (Line 3 - Line 4)		
6. Adjusted Reimbursable Bad Debts Multiply Line 5 by 65%)		(DMA-4, Line 11)

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

(1)	Pneumococcal (2)	Influenza (3)
1. Cost Per Pneumococcal and Influenza Vaccine Injection (CMS Form 224-14, W/S B-1, Line 12)		
2. Number of Pneumococcal and Influenza Vaccine Injections Administered to Medicaid Beneficiaries (From 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-4, Line 6		

NPI NO.	COST OF ALLOWABLE GRADUATE MEDICAL EDUCATION (GME) 2017 COST REPORT	Reporting Period From: 1/0/1900 To: 1/0/1900
PROVIDER NO.		

(1)	(2)
1. Number of Intern and Resident Visits to Medicaid Beneficiaries (CMS Form 224-14, Worksheet S-3, Part I, Column 3, Line 6)	
2. Total Number of All Intern and Resident Visits (CMS Form 224-14, Worksheet S-3, Part I, Column 5, Line 6)	
3. Percentage of Intern and Resident visits to Medicaid Beneficiaries (Line 1 divided by Line 2)	0%
4. Total Allowable GME Costs (CMS Form 224-14, Worksheet A, Column 7, Line 47)	
5. Total Medicaid Allowable GME Costs (Multiply Line 3 by Line 4). Transfer to DMA-4, Line 7.	0

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

2017 COST REPORT

	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. Total Reimbursable Cost from DMA-4			(DMA-4, Line 8 + DMA-4, Line 11)
5. Greater of PPS Payment or Reimbursable Cost			**Cost Settlement**
6. Amount Received from Medicaid			(DMA-5, Line 6)
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 Assistanc****e* 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 A PPS RECONCILED PROVIDER, COMPLETE DMA-10A & 10B.

RUN DATE: 8/15/17 SCHEDULE DMA-10A

NPI NO. PROVIDER NO.	PPS RECONCILIATION SCHEDULE **PPS RECONCILED PROVIDERS ONLY**	Reporting Period From: To:

2017 COST REPORT

	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-5, Line 6)
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 Assistanc e*** 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-9 FOR THE PPS RECONCILIATION.

Run Date 8/15/17

SCHEDULE DMA-10B

NPI No.	0
Provider No.	0

SCOPE OF SERVICE CHANGES

PPS RECONCILED PROVIDERS ONLY

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

2017 COST REPORT

(1)	**No Change** (2)	**Added Service** (3)	**Date Added** (4)	**Discon-tinued Service** (5)	**Date Discon-tinued** (6)
1. FQHC 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.					
h. Durable Medical Equipment.					
i. Home Health					
j. Other (Specify)					

Comments:

Please provide one form per NPI annually.