FEDERALLY QUALIFIED HEALTH CENTERS

DIVISION OF HEALTH BENEFITS

MEDICAID COST REPORTING SCHEDULES

2020

INSTRUCTIONS

Reporting Deadline: **Due by the end of the fifth month of the year ending service period**

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

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

Effective for dates of service occurring January 1, 2001 and after, FQHCs are reimbursed on a prospective payment rate. (PPS Provider)

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

Effective for 2018 cost report year, North Carolina Health Choice reconciliation schedules have been added to the Medicaid cost report (DHB-5A & 10A).

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES
Division of Health Benefits

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

October 21, 2020

Dear FQHC Provider:

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

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

- A full copy of your facility's signed and certified Medicare cost report (CMS 224-14).
- A copy of your facility's "crosswalk" working trial balance in Excel format with sufficient detail to support the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicare report.
- Supporting documentation and working papers including, but are not limited to, calculation of costs for the Medicaid report.
- Log of bad debts, if applicable.
- Log of pneumococcal and influenza immunizations administered to Medicaid beneficiaries above eighteen years old included on DHB-7. This log must include each beneficiary's Medicaid ID number and birthdate.
- Financial Statements, audited (if available) or unaudited, at time of submission.
- List of all State and Federal grant revenues including the title of the grant and amount of revenues for the reporting period.

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

US MAIL ADDRESS

DHHS – NC Medicaid
Division of Health Benefits
Attn: Provider Audit Section – John Mathewson
2501 Mail Service Center
Raleigh, NC 27699–2501

OVERNIGHT / EXPRESS MAIL ADDRESS

DHHS – NC Medicaid
Division of Health Benefits
Attn: Provider Audit Section – John Mathewson
820 South Boylan Avenue-McBryde South
Raleigh, NC 27603

If a settlement is due the Medicaid program, make check payable to ***Division of Health Benefits*** for the amount due. Please ensure NPI and FY appear on the check and remit it under separate cover to:

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

If you have questions, please contact John "Jeff" Mathewson at (919) 527-7161 or e-mail john.mathewson@dhhs.nc.gov.

Sincerely,

John "Jeff" Mathewson, CPA
Audit Manager

DHB FQHC MEDICAID SCHEDULES
INSTRUCTIONS

RECOMMENDED SEQUENCE FOR COMPLETING **MEDICAID** AND **NC HEALTH CHOICE** SCHEDULES

Note: Medicare Cost Reporting Worksheets (CMS-224-14) must be completed before the Medicaid Schedules are prepared.

Step Number	Schedule	Cost Report Page	Instructions
1	Facesheet	1	Page 4, complete sections 1 – 7
2	DHB - 1	2	Page 5, complete schedule
3	DHB - 2	3	Pages 5 – 6, complete schedule
4	DHB - 3	4	Pages 6 – 7, complete schedule
5	DHB - 4	5	Page 8 – 9, complete Lines 1-5
6	DHB - 5	6	Page 9 – 10, complete schedule
7	DHB - 6	8	Page 10, complete schedule
8	DHB - 7	9	Page 10 – 11, complete schedule
9	DHB - 4	5	Page 8 – 9, complete Line 6
10	DHB – 8	10	Page 11, complete schedule
11	DHB – 4	5	Page 8 – 9, Lines 7 - 12
12	DHB - 9	11	Page 11 – 12, **Cost-Settled Providers ONLY**, complete schedule
13	DHB – 10	12	Page 12 – 13, **PPS Reconciled Providers ONLY**, complete schedule
14	DHB-5A	7	Page 13 – 14, complete schedule.
15	DHB- 10A	13	Page 14, complete schedule
16	Facesheet	1	Pages 15, Certification Statement
17	Cost Report Checklist		Page 16, ensure documents on the list are submitted to DHB

DHB FQHC MEDICAID SCHEDULES
INSTRUCTIONS

DHB-SCHEDULES

PAGE 1 - GENERAL INFORMATION AND CERTIFICATION

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

1. Check appropriate box identifying the provider's Medicaid Reimbursement Status.

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

2. Enter name, address, county and telephone number.

3. Enter cost reporting period. This period must coincide with the Medicare Cost Report.

4. Enter **Employer Identification Number** (new for FY 2019)

5. Enter all facility NPI numbers and Medicaid provider numbers (if assigned). If additional space is needed, attach a separate sheet with the additional facility NPI and Medicaid provider numbers.

6. Check appropriate box identifying type of control.

7. Enter the name and contact information for the person we should contact if we have any questions about the cost report schedules.

8. If Notice of Program Reimbursement should be mailed to a different address than the one entered under 2. (above), enter that mailing address here.

Certification Statement

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

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

DHB FQHC MEDICAID SCHEDULES
INSTRUCTIONS

DHB-1 / PAGE 2 - COST OF MEDICAID CORE SERVICES

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

Column 1

Line 1

Enter Cost per Covered Visit from CMS Form 224-14, W/S B, Part I, Line 13, Column 6.

Line 2

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

Line 3

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

DHB-2 / PAGE 3 - COST OF OTHER AMBULATORY SERVICES

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

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

Line 1a

Medicare Worksheet A, Column 7, Lines 60-69. Enter the cost of Dental Services.

Line 1b

Medicare Worksheet A, Column 7, Line 60-69. Enter the cost of Health Check Services (formerly EPSDT).

Line 1c

Medicare Worksheet A, Column 7, Lines 60-69. Enter the cost of Radiology Services (on site).

Line 1d

Medicare Worksheet A, Column 7, Lines 60-69. Enter the cost of Norplant Services.

Line 1e

Medicare Worksheet A, Column 7, Lines 60-69. Enter the cost of Physician Hospital Services.

Line 1f

Medicare Worksheet A, Column 7, Lines 60-69. Enter the cost of Pharmacy Services.

Line 1g

Medicare Worksheet A, Column 7, Line 60-69. Enter cost of Other Medicaid Covered Services.

DHB-2 / PAGE 3 - continued

Line 2
Enter cost of all services excluding overhead from Medicare Cost Report, W/S A, Column 7, Line 100 minus Line 13 plus Line 9.

Line 3
Enter percentage of Other FQHC Services. Divide Line 1 by Line 2.

Line 4
Enter Net Facility Overhead from Medicare Cost Report, W/S A, Column 7, Line 13 minus Line 9.

Line 5
Compute Overhead applicable to Other FQHC Services. Multiply Line 3 times Line 4. Transfer amount to Schedule DHB-3, Column 2, Line 3.

DHB-3 / PAGE 4 - ALLOCATION OF OVERHEAD COST

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

Column 2
Lines 1a – f.
Transfer costs from Schedule DHB-2 / Page 3 to the corresponding cost center.

Line 2
Total of Lines 1a - g.

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

Line 4
Divide Line 3 by Line 2. Round this amount to the fifth decimal place (0.00000).

Column 3
Line 1a
Multiply Unit Cost Multiplier (Column 2, Line 4) times Dental Cost (Column 2, Line 1a); enter amount on Line 1a.

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

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

DHB-3 / PAGE 4 - continued

Line 1d

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

Line 1e

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

Line 1f

Multiply Unit Cost Multiplier (Column 2, Line 4) times Pharmacy Services Cost (Column 2, Line 1f); enter amount on Line 1f.

Line 1g

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

Line 2

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

Column 4

Lines 1a – 1g

Total of Columns 2 and 3 for each Line.

Line 2

Total of Columns 2 and 3.

Column 5

Lines 1a – 1g

Total number of encounters / units of service for **all** patients served by the provider, including (but not limited to) patients with Medicare, Medicaid, Health Choice, private insurance, self pay, and charity / free / uncompensated care.

Enter Encounters for Dental, Healthcheck, and Norplant. Enter units for Radiology, Physician Hospital, Pharmacy, and Other.

Column 6

Lines 1a – 1g

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

DHB-4 / PAGE 5 - DETERMINATION OF MEDICAID REIMBURSEMENT

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

Column 2

Lines 1a – 1g

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

Column 3

Lines 1a – 1g

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

Enter encounters for Dental, Healthcheck, and Norplant. Enter units for Radiology, Physician Hospital, Pharmacy, and Other.

Column 4

Lines 1a – 1g

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

Line 2

Enter Subtotal of Lines 1a – 1g.

Line 3

Enter sum of Medicaid cost for Physician Hospital Services from Column 4, Line 1e.

Line 4

Subtract Line 3 from Line 2.

Line 5

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

Line 6

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

Line 7

Enter Total Medicaid Cost of Graduate Medical Education Pass Through from DHB-8, Line 5.

Line 8

Enter Total of Lines 4, 5, 6 and 7.

Line 9

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

DHB-4 / PAGE 5 - continued

Line 10
Subtract Line 9 from Line 8.

Line 11
Enter Amount of Adjusted Reimbursable Bad Debts from Schedule DHB-6 / Page 8, Line 6.

Line 12
Compute Amount Due Provider (Program). Add Line 10 and Line 11.

DHB-5 / PAGE 6 - SUMMARY OF MEDICAID PAYMENTS

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

Column 2

Lines 1a – 1g
Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2
Enter Received / Receivable amount for Core Services based on the facility's records

Line 3
Enter Received/Receivable Third Party Liability amount for Ambulatory and Core Services based on facility's records.

Line 4
Subtotal Lines 1a-1g, Line 2, and Line 3.

Line 5
Enter Received/Receivable amount for Physician Hospital Services from Line 1e.

Line 6
Compute Total Medicaid Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DHB-4/Page 5, Column 4, Line 9 and Schedule DHB 9/Page 11, Line 6.

Column 3

Lines 1a – 1g
Enter NPI numbers used by NC TRACKS to make payments for each Ambulatory Service. Please note, if more space is needed, NPIs may be listed in the NPI section at the bottom of the page.

Line 2
Enter NPI numbers used by NC TRACKS to make payments for Core Services.

DHB-5 / PAGE 6 - continued

Line 3
Enter NPI numbers which Third Party Liability payments were made for Medicaid covered services.

DHB-6 / PAGE 8 - BAD DEBTS

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

Column 2
Line 1
Enter the total co-payment amount billed to Medicaid patients from the facility's records.

Line 2
Enter the co-payment amounts received from Medicaid patients from the facility's records.

Line 3
Compute Medicaid Bad Debts. Subtract Line 2 from Line 1.

Line 4
Enter any recovery of previous Medicaid amounts written off as bad debts from the facility's records.

Line 5
Compute Net Bad Debts. Subtract Line 4 from Line 3.

Line 6
Compute the Adjusted Reimbursable Bad Debts. Multiply Line 5 by 65 percent. Transfer to DHB-4, Line 11.

DHB-7 / PAGE 9 - COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES

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

Columns 2 and 3
Line 1
Enter cost of Pneumococcal and Influenza Vaccine Injections and their administration in the applicable column from the Medicare Cost Report, Worksheet B -1, Line 12.

Line 2
Enter the number of Pneumococcal and Influenza Vaccine Injections administered to Medicaid beneficiaries in the applicable column. This information is from the provider's records.

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

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

DHB-7 / PAGE 9 - continued

Line 3
Multiply Cost per Vaccine Injection (Line 1) times number of Medicaid Vaccine Injections (Line 2).

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

DHB-8 / PAGE 10 - COST OF ALLOWABLE GRADUATE MEDICAL EDUCATION (GME)

The purpose of this schedule is to compute the Medicaid cost of Allowable Graduate Medical Education (GME) based on the number of Intern and Resident visits administered to Medicaid beneficiaries.

Column 2

Line 1
Enter the number of Intern and Resident Visits to Medicaid Beneficiaries from the CMS Form 224-14, Worksheet S-3, Column 3, Line 6.

Line 2
Enter the total number of all Intern and Resident visits from Worksheet S-3, Column 5, Line 6.

Line 3
Compute the Medicaid percentage of Intern and Resident visits by dividing Line 1 by Line 2.

Line 4
Enter the Allowable GME costs from Worksheet A, Column 7, Line 47.

Line 5
Compute the Total Medicaid Allowable GME costs by multiplying Line 3 by Line 4. Transfer to DHB-4, Line 7.

DHB-9 / PAGE 11 – MEDICAID PPS RECONCILIATION SCHEDULE FOR COST-SETTLED PROVIDERS ONLY

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

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

Line 1
Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

Line 2
Enter PPS rate from DHB Provider Reimbursement.

DHB-9 / PAGE 11 - continued

Line 3
Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4
Enter Total Reimbursable Costs from DHB-4. Sum of Line 8 and Line 11.

Line 5
Enter Greater of Line 3 or Line 4.

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

Line 7
Subtract Line 5 from Line 6. If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Health Benefits*** to the address below. The FY and facility's primary NPI must appear on the check:

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

DHB-10 / PAGE 12 – MEDICAID PPS RECONCILIATION SCHEDULE FOR PPS PROVIDERS ONLY

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

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

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

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

Line 1
Compute Total Medicaid Encounters. Enter subtotal of lines a - e.

DHB-10 / PAGE 12 - continued

Line 2
Enter PPS rate from DHB Provider Reimbursement.

Line 3
Compute Total Prospective Payments. Multiply Line 1 times Line 2.

Line 4
Enter Amount Received from Medicaid from DHB-5, Line 6.

Line 5
Subtract Line 4 from Line 3. If this is a negative amount (Due Program), the total amount due **must** be remitted under separate cover with check made payable to ***Division of Health Benefits*** to the address below. The FY and facility's primary NPI must appear on the check:

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

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

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

Column 2

Lines 1a – 1g
Enter Received / Receivable amount for each Ambulatory Service based on the facility's records.

Line 2
Enter Received / Receivable amount for Core Services based on the facility's records.

Line 3
Enter Received / Receivable Third Party Liability amount for Ambulatory and Core Services based on the facility's records.

Line 4
Subtotal Lines 1a – 1g, Line 2, and Line 3.

Line 5
Enter Received / Receivable amount for Physician Hospital Services from Lines 1e.

Line 6
Compute Total Health Choice Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DHB-10A / Page 13, Line 4.

DHB-5A / PAGE 7 - continued

Column 3

Lines 1a – 1g

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

Line 2

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

Line 3

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

DHB-10A / PAGE 13 - NC HEALTH CHOICE (TITLE XXI) PPS RECONCILIATION SCHEDULE

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

Lines a - e

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

Line 1

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

Line 2

Enter PPS rate from DHB Provider Reimbursement.

Line 3

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

Line 4

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

Line 5

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

After completing all schedules, print and complete the Certification Form as instructed on next page.

DHB FQHC MEDICAID SCHEDULES
INSTRUCTIONS

CERTIFICATION STATEMENT

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

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

QUESTIONS ABOUT COST REPORT PREPARATION:

If you have questions about the preparation of the **FQHC** cost reporting forms, please contact John "Jeff" Mathewson at (919) 527-7161 or e-mail john.mathewson@dhhs.nc.gov

DHB FQHC/RHC
MEDICAID COST REPORT
CHECKLIST

PPS Reconciled providers must submit a full copy of your signed and certified facility Medicare cost report (CMS 224-14) **along with your original Medicaid FQHC cost report.**

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

_____ A full copy of your signed and certified facility Medicare cost report (CMS 224-14).

_____ A copy of your facility "crosswalk" working trial balance in Excel format to support Medicare report.

_____ Supporting documentation and working papers including calculation of costs for the Medicare cost report, in Excel format whenever possible

_____ Supporting documentation and working papers including calculation of costs for the Medicaid cost report, in Excel format whenever possible

_____ Log of bad debts in Excel format, if applicable.

_____ Log of vaccines administered to Medicaid beneficiaries included on DHB-7, in Excel format. This log must include each beneficiary's Medicaid ID number and date of birth.

_____ Financial Statements, audited (if available) or unaudited, at time of submission.

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