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

DEPARTMENT OF HUMAN RESOURCES - DIVISION OF MEDICAL ASSISTANCE

2016 RURAL HEALTH CLINIC

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 _____ (Name of Facility) for the cost report period beginning _____ 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: 1/4/18

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

	2015 (1)	2016 (2)	TOTAL (3)
1. Rate for Medicare Covered Visits (W/S C, Part I, Line 9).			
2. Medicaid Covered Visits for Core Services (From Provider Records) Including Mental Health Services			
3. Medicaid Cost for Core Services (Line 1 x 2)			

RUN DATE: 1/4/18

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

1. Cost Other Than RHC Services - (Sum of Lines 1a - 1h) (Figures are from Medicare W/S A, Column 7, Lines 51 - 56)		
a. Pharmacy		
b. Dental		
c. Health Check Services (formerly EPSDT)		
d. Radiology Services (on-site)		
e. Norplant Services		
f. Physician Hospital Services		
g. Health Check Coordinator.	**(Note 1)**	
h. Other.		
*2. Cost of All Services - excluding overhead (W/S B, Line 12)		
3. Percentage of Other RHC Services (Line 1 / 2)		
4. Net Facility Overhead (W/S B, Line 14.02)		
5. Overhead Cost Applicable to RHC Services (Line 3 x 4)		

*WIC Program
Patient Transportation
Outstationed Eligibility Workers

Note 1: No entry required on this schedule. Health Check Coordinator total cost should be reported on Schedule DMA-4, Line 1g, Column 4.

RUN DATE: 1/4/18

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

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

* Number of prescriptions

** Encounter

Note 1: No entry required on this schedule. Health Check Coordinator total cost should be reported on Schedule DMA-4, Line 1g, Column 4.

NPI NO. PROVIDER NO.	DETERMINATION OF MEDICAID REIMBURSEMENT 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. RHC Services				
a. Pharmacy				
b. Dental				
c. Health Check Services (Formerly EPSDT)				
d. Radiology Services (on-site)				
e. Norplant Services				
f. Physician Hospital Services				
g. Health Check Coordinator	**(Note 1)**	**(Note 1)**		
h. Other (Specify)				
2. Subtotal				
3. Less: Physician Hospital Services and Health Check Coordinator				
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. Total Reimbursable Cost (Line 4 + 5 + 6)				
8. Amount Received/Receivable from Medicaid (From Provider Records)				(DMA-5, Line 6)
9. Amount Due Provider <Program> Exclusive of Bad Debts (Line 7 - 8)				
10. Reimbursable Bad Debts				(DMA-6, Line 5)
11. Total Amount Due Provider <Program> (Line 9 + 10)				

Note 1: No entry required in these blocks. Health Check Coordinator total cost should be reported on Schedule DMA-4, Line 1g, Column 4.

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

(1)	Amount * (From Provider Records) (2)	Provider Number/s (3)	
1. RHC Payments			
*a. Pharmacy			
*b. Dental			
c. Health Check Services (formerly EPSDT) .			
*d. Radiology Services (on-site).			
e. Norplant Services			
f. Physician Hospital Services			
g. Health Check Coordinator			
h. Other (Specify)			
2. Core Services			
3. Third Party Liability			
4. Subtotal			
5. Less: Physician Hospital Services and Health Check Coordinator			
6. Total Medicaid Payments (Line 4 - 5)			(DMA-4, Line 8)

*** 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 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. Net Bad Debts (Line 3 - 4)		(DMA-4, Line 10)

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

(1)	Pneumococcal (2)	Seasonal Influenza (3)
1. Cost Per Pneumococcal and Influenza Vaccine Injection (Supplemental 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. PROVIDER NO.	PPS RECONCILIATION SCHEDULE **COST-SETTLED PROVIDERS ONLY**	Reporting Period From: To:

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 7 + DMA-4, Line 10)
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-9A & 9B.

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

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-8 FOR THE PPS RECONCILIATION.

Run Date 1/4/18

SCHEDULE DMA-9B

NPI No.	0
Provider No.	1/0/1900

SCOPE OF SERVICE CHANGES

PPS RECONCILED PROVIDERS ONLY

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

0 COST REPORT

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

Comments:

Please provide one form per NPI annually.