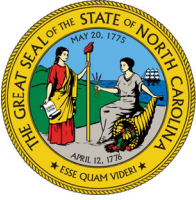


**DHB Provider Audit Section  
ICF-IID Group Homes  
Guidance for Cost Report Preparation**

**FYE: June 30, 2026**

**Revised June 3, 2026**



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**  
Division of Health Benefits

**JOSH STEIN** • Governor  
**DEV DUTTA SANGVAI** • Secretary  
**MELANIE BUSH** • Deputy Secretary, NC Medicaid

June 3, 2026

Dear Group Home:

In accordance with the Reimbursement Plan for Intermediate Care Facilities for Individuals with Intellectual Disabilities, we are furnishing the software for the 2026 Medicaid cost reports.

The downloadable Excel software will enable you to input and generate your 2026 Medicaid cost report. The User's Guide includes instructions for generating a blank cost report and inputting data to generate your completed cost report. **The furnished software is not to be modified in any manner.**

The cost report for the fiscal year ended June 30, 2026, is **due to be filed by Wednesday, September 30, 2026**. We do not plan to issue any extensions from this due date. The cost report **must** be filed electronically by e-mail along with a signed Certification Form and the working trial balance to [Medicaid.LTCCostReport@dhhs.nc.gov](mailto:Medicaid.LTCCostReport@dhhs.nc.gov):

If a settlement is due the Medicaid Program, make check payable to Division of Health Benefits for the amount due and remit it under separate cover to:

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

Below, we have furnished guidance to assist you in preparing the cost reporting forms in accordance with our requirements. Also, Frequently Asked Questions (FAQs) can be accessed on the website page. If you have questions regarding the cost reporting forms, please contact the DHB Audit Section via e-mail at [Medicaid.LTCCostReport@dhhs.nc.gov](mailto:Medicaid.LTCCostReport@dhhs.nc.gov).

Sincerely,

**Atul Bhikha**  
Audit Manager  
Provider Audit

**NC MEDICAID**  
**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH BENEFITS**

LOCATION: 1915 Health Services Way, Raleigh, NC 27607  
MAILING ADDRESS: 2501 Mail Service Center, Raleigh, NC 27699-2501  
[www.ncdhhs.gov](http://www.ncdhhs.gov) • TEL: 919-855-4100 • FAX: 919-733-6608  
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**DHB Provider Audit Section  
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FYE: June 30, 2026**

**COMPLETION OF SCHEDULES**

A Consolidated Health Care Assessment Tax Schedule has been created to provide easier filing of the tax assessment for group homes with no Medicaid Days in FY25. These schedules can be accessed via the DHB Audit Section web site. To complete the schedules, on the Main tab go to Line 1 “PRIMARY HOME” and select the name of the facility from the drop-down list and then complete the C-Census tab. For providers with more than one group home, complete the Main tab for the group home with the Lowest Provider Number and complete the C-Census tab for that home. Select the additional homes on the Facility tab by choosing the name of each home from the drop-down list. Enter the census data for the additional homes on the More Census tab. An originally signed copy of the Certification form for the main group home must be mailed to DHB. Also required is an electronic or hard copy of each facility’s Monthly Census summary.

For FY25 cost reports, all providers are required to furnish copies of existing, renewed, or amended facility and day program lease agreements which support any lease expense identified in the cost report. Failure to support lease agreements with proper documentation may result in disallowance of lease expense.

**Sch. G - Revenues** – Beginning with FY20, providers must complete Sch. G to show a computation of their Net Patient Revenues, which is total revenue from all sources less allowable expenses.

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**Fire Protection Sprinkler System Schedule** – This schedule will have to be completed by those group homes that have received partial reimbursement for the installation of a fire protection sprinkler system. This schedule can be completed by accessing the DHB Provider Audit Section web site. For further information on reimbursement of fire protection sprinkler systems, please call (919) 527-7160.

**Limitations**

The established cost limitations for ICFIID group home cost reports for fiscal year ended June 30, 2026, are as follows:

<b>Medical Director:</b>	<b>\$250 per bed annually</b>
<b>Management Fees:</b>	<b>\$7.13 per patient day</b>
<b>Capital/Lease Costs:</b>	<b>\$6,546 annually per bed</b>
<b>Director's Fees:</b>	<b>\$2,400 annually or \$200 per meeting</b>

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**Owner or Administrator Salary:**

<b>\$57,570</b>	<b>(1-50 beds)</b>
<b>\$69,912</b>	<b>(51-99 beds)</b>
<b>\$74,024</b>	<b>(100-149 beds)</b>
<b>\$79,660</b>	<b>(150-199 beds)</b>
<b>\$90,469</b>	<b>(200-249 beds)</b>

**Prior Year Cost Reports**

ICFIID cost report preparers are required to review the prior year desk and field audited cost reports and incorporate all applicable adjustments and/or recommendations into the 2026 cost reports. (CMS Pub 15-1, Section 2905.2)

**Cost reports filed for fiscal year ended June 30, 2026, without all schedules properly completed will be considered incomplete and subject to suspension of all payments until schedules are properly completed.**

**Field Audits**

If your ICFIID facility is selected for a field audit, financial records supporting the cost report must be made available to the field auditors on an agreed upon timetable. **Failure to furnish requested financial records might result in the repayment of all Medicaid payments.**

**Other Questions About Cost Report Preparation?**

If you have questions about the preparation of the cost reporting forms, please contact the DHB Audit Section at (919) 527-7171 or email [Medicaid.LTCCostReport@dhhs.nc.gov](mailto:Medicaid.LTCCostReport@dhhs.nc.gov).

**ICFIID Cost Report Checklist**  
**FYE: June 30, 2026**

The following items must be emailed to DHB by September 30, 2026:

- \_\_\_\_\_ The Combined Cost Report for the Audit Section
- \_\_\_\_\_ Signed and dated copy of the Information/Certification Form
- \_\_\_\_\_ Signed and dated copy of the Provider Health Care Assessment Certification Form, if these forms are completed by the individual Group Home
- \_\_\_\_\_ Working Trial Balance for the ICFIID facility (preferably in Excel).
- \_\_\_\_\_ Copy of contracts for new or renewed lease agreements