FEDERALLY QUALIFIED HEALTH CENTERS
&
RURAL HEALTH CLINICS

DIVISION OF MEDICAL ASSISTANCE

MEDICAID SCHEDULES

2005

INSTRUCTIONS

North Carolina Department of Health and Human Services

Division of Medical Assistance

Audit Section

421 Fayetteville Street Mall, Raleigh, NC 27601
2501 Mail Service Center - Raleigh, N.C. 27699-2501
Tel: (919) 647-8060 Fax: (919) 715-4711

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
Jim Flowers, Chief Audit Section

March 1, 2006

Dear FQHC \ RHC Provider:

In accordance with the Medicaid Participation Agreement Paragraphs 6 and 7, FQHC\RHC providers are required to file an annual year ending cost report with the Division of Medical Assistance. Providers can access the cost reporting forms and instructions on-line at http://www.dhhs.state.nc.us/dma/icfmr/fqhccost.htm 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\RHC cost report**:

- A copy of your facility Medicare cost report.
- A copy of your facility "crosswalk" working trial balance to support 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.
- Defined chart of account.
- Log of bad debts, if applicable.
- Financial Statements, audited or unaudited, at time of submission.

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

US Mail

Audit Section
Attn: Misty Bryant (for FQHC)
or Jason Hockaday (for RHC)
Division of Medical Assistance
2501 Mail Service Center
Raleigh, NC 27699–2501

Express Mail/Shipping

Audit Section
Attn: Misty Bryant (for FQHC)
or Jason Hockaday (for RHC)
Division of Medical Assistance
421 Fayetteville St. Mall
Raleigh, NC 27601

If a settlement is due the Medicaid program, make check payable to ***Division of Medical Assistance*** for the amount due and remit it under separate cover to:

DHHS Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699–2022

I If you have questions, please contact Misty Bryant at (919) 647-8064 or e-mail misty.bryant@ncmail.net for FQHC's or contact Jason Hockaday at (919) 647-8087 or e-mail jason.hockaday@ncmail.net for RHC's.

Sincerely,

Jim Flowers

DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS

RECOMMENDED SEQUENCE FOR COMPLETING MEDICAID SCHEDULES

The Medicaid Schedules are to be completed after the Medicare Cost Reporting Worksheets (FORM HCFA-222-92 <3/93>) are completed.

Step Number	Schedule	Cost Report Page	Instructions
1	Geninfo	1	Page 2. Complete **Sections 1 – 5**.
2	DMA - 1	2	Page 3. Complete Schedule.
3	DMA - 2	3	Pages 4 - 5. Complete Schedule.
4	DMA - 3	4	Pages 6 - 7. Complete Schedule.
5	DMA - 4	5	Page 8 - 9. **Complete Lines 1 - 5**.
6	DMA - 5	6	Page 10. Complete Schedule.
7	DMA - 6	7	Pages 11. Complete Schedule.
8	DMA - 7	8	Page 11. Complete Schedule.
9	DMA - 4	5	Page 8 - 9. **Complete Lines 6 - 11**.
10	DMA - 8	9	Page 12. Complete Schedule.
11	Geninfo	1	Page 2. Complete **Certification Statement**.

DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS

DMA-SCHEDULES

GENERAL INFORMATION AND CERTIFICATION - PAGE 1

Warning: If you downloaded the Excel spreadsheet and are keying data into a worksheet, please remember you need only key data into the lightly shaded cells. Each worksheet contains formulas that process data only from the shaded cells and will not work correctly if you make entries in unshaded fields. If you experience problems with using Excel, simply print a blank copy of each schedule and fill it out using a pen or typewriter.

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

1. Enter name, address, all Medicaid provider numbers assigned to facility, county and telephone number. If space is not ample to enter all provider numbers, attach schedule. If filing a consolidated cost report, attach schedule identifying all facilities and provider numbers.

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

3. Check appropriate box identifying type of control.

4. Enter individual we should contact to answer questions about cost report schedules.

5. Enter address we should mail all Medicaid settlements if different from address of facility in Item 1.

6. 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.

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

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

Columns 1 and 2 must be completed if the rate for Medicare Covered Visits is different between 2004 (Column 1) and 2005 (Column 2). Column 3 is total of Columns 1 and 2. Column 1 should be completed based on visits furnished during 2004. Column 2 should be completed based on visits furnished during 2005. If rate is the **same** for both periods, you may complete Column 3 covering the entire cost reporting period.

The rate is the Medicare settlement rate.

Line 1
Enter from the Medicare Cost Report, Worksheet C, Part I, Line 9, corresponding columns.

Line 2
Enter Medicaid covered visits for Core Services excluding Mental Health Services, from provider's records.

Line 3
Compute cost of Core Services excluding visits for Mental Health Services. Multiply Line 1 times Line 2.

Line 4
Enter Medicaid covered visits for Mental Health Services from provider's records.

Line 5
Compute cost of visits for Mental Health Services. Multiply Line 1 times Line 4.

Line 6
Compute Limit Adjustment on Mental Health Services. Multiply Line 5 times 62.5%.

Line 7
Compute Total Medicaid Cost. Line 3 plus Line 6.

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

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.

Line 1
Enter Cost of Other FQHC Services excluding overhead from Medicare Cost Report, Worksheet A, Column 7, Line 57 less any cost for Healthcheck Coordinator. This amount **must** agree with the total of Lines 1a - 1i.

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

Line 1a
Worksheet A, Column 7, Line 51 of the Medicare Cost Report.

Line 1b
Worksheet A, Column 7, Line 52 of the Medicare Cost Report.

Line 1c
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Health Check (formerly EPSDT) Services (*Compensation and fringe benefits of Physician, Nurse Practitioner, or Physician's Assistant and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1d
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Maternity Care Coordination Services (*Compensation and fringe benefits of Social Worker or Nurse and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1e
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Child Services Coordination (*Compensation and fringe benefits of Social Worker or Nurse and Other) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1f
Worksheet A, Column 7 of the Medicare Cost Report. Cost of on-site Radiology Services identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1g
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Norplant Services (*Compensation and fringe benefits of Physician and Kit) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

PAGE 3 / DMA-2 continued

Line 1h
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Physician Hospital Services (*Compensation and fringe benefits of Physician and Professional Liability Insurance) identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

Line 1i
No entry required on this line. Enter total cost of Healthcheck Coordinator on schedule DMA 4, Line 1i, Column 4.

Line 1j
Worksheet A, Column 7 of the Medicare Cost Report. Cost of Other Medicaid covered services identified by the facility which would be included on Worksheet A, Column 7, Lines 53 - 56.

***This is not an all-inclusive identification of costs which may be applicable to this service.**

Line 2
Enter cost of all services excluding overhead from Medicare Cost Report, Worksheet B, Line 12.

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

Line 4
Enter Total Overhead from Medicare Cost Report, Worksheet B, Line 14.

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

ALLOCATION OF OVERHEAD COST - PAGE 4 / DMA-3

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 - 1j

Transfer costs from Schedule DMA-2 / Page 3 to the corresponding cost center.

Line 2

Total of Lines 1a - 1j.

Line 3

Enter overhead cost from Schedule DMA-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 Pharmacy Cost (Column 2, Line 1a) and enter amount on Line 1a.

Line 1b

Multiply Unit Cost Multiplier (Column 2, Line 4) times Dental Cost (Column 2, Line 1b) and enter amount on Line 1b.

Line 1c

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

Line 1d

Multiply Unit Cost Multiplier (Column 2, Line 4) times Maternity Care Coordination Cost (Column 2, Line 1d) and enter amount on Line 1d.

Line 1e

Multiply Unit Cost Multiplier (Column 2, Line 4) times Child Services Coordination Cost (Column 2, Line 1e) and enter amount on Line 1e.

Line 1f

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

Line 1g

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

PAGE 4 / DMA-3 continued

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

Line 1i
No entry required on this line. Enter total cost of Healthcheck Coordinator on schedule DMA 4, Line 1i, column 4.

Line 1j
Multiply Unit Cost Multiplier (Column 2, Line 4) times Other Specified Cost (Column 2, Line 1i) and enter amount on Line 1i.

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

Column 4
Lines 1a - 1j
Total of Columns 2 and 3 for each Line.

Line 2
Total of Columns 2 and 3.

Column 5
Lines 1a - 1j
Total number of encounters / units of service for **all** recipients served by the provider. This would include Medicare, Medicaid, private, and insurance recipients.

Number of prescriptions must be used for Pharmacy and encounters / units of service for all other Ambulatory Services.

Column 6

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

DETERMINATION OF MEDICAID REIMBURSEMENT - PAGE 5 / DMA-4

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 - 1j

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

Column 3

Lines 1a - 1h, and 1j

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.

Line 1i

No entry this block. Enter Total Cost of Healthcheck Coordinator in Line 1i, Column 4.

Column 4

Lines 1a - 1h, and 1j

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

Line 1i

Enter Total Cost of Healthcheck Coordinator.

Line 2

Enter Subtotal of Lines 1a - 1j.

Line 3

Enter sum of Medicaid cost for Physician Hospital Services and Healthcheck Coordinator from Column 4, Lines 1h and 1i.

Line 4

Subtract Line 3 from Line 2.

Line 5

Enter Total Medicaid Core Cost transferred from Schedule DMA-1 / Page 2, Column 3, Line 7.

Line 6

Enter Total Medicaid Cost of Pneumococcal and Influenza Vaccine Injections transferred from Schedule DMA-7 / Page 8, Column 2, Line 4.

Line 7

Enter Total of Lines 4, 5, and 6.

PAGE 5 / DMA-4 continued

Line 8
Enter Amount Received / Receivable from Medicaid based on Core and Ambulatory Services furnished to Medicaid Recipients. Amount transferred from Schedule DMA-5, Page 6, Column 2, Line 6.

Line 9
Subtract Line 8 from Line 7.

Line 10
Enter Amount of Bad Debts from Schedule DMA-6 / Page 7, Line 5.

Line 11
Compute Amount Due Provider (Program). Add Lines 9 and 10. Total should match DMA-8, Line 4.

SUMMARY OF MEDICAID PAYMENTS - PAGE 6 / DMA-5

The purpose of this schedule is to identify Medicaid Received / Receivable amounts and provider numbers for which EDS rendered payments. These amounts are applicable to Core and Ambulatory Services furnished during the cost reporting period. **Carolina Access and Medicaid crossover amounts are not included. Co-payments for Ambulatory Services are included**.

Column 2

Lines 1a - 1j

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 - 1j and Line 2.

Line 5

Enter Received / Receivable amount for Physician Hospital Services and Healthcheck Coordinator from Lines 1h and 1i.

Line 6

Compute Total Medicaid Payments. Subtract Line 5 from Line 4. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 8 and Schedule DMA-8 / Page 9, Line 6.

Column 3

Lines 1a - 1j

Enter provider numbers used by EDS to make payments for each Ambulatory Service.

Line 2

Enter provider numbers used by EDS to make payments for Core Services.

Line 3

Enter provider numbers which Third Party Liablilty payments were made for Medicaid covered services.

BAD DEBTS - PAGE 7 / DMA-6

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

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. Transfer this amount to Schedule DMA-4 / Page 5, Column 4, Line 10.

COST OF PNEUMOCOCCAL AND INFLUENZA VACCINES - PAGE 8 / DMA-7

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 recipients.

Columns 2 and 3

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

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

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 DMA-4 / Page 5, Column 4, Line 6.

PPS RECONCILIATION SCHEDULE – PAGE 9 / DMA-8

The purpose of this schedule is to compute PPS payments 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 DMA Rate Setting.

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

Line 4
Enter Total Reimbursable Costs from DMA-4. Sum of Line 7 and Line 10.

Line 5
Enter Greater of Line 3 or Line 4.

Line 6
Enter Amount Received from Medicaid from DMA-5 Line 6.

Line 7
Subtract Line 6 from Line 5. 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 Medical Assistance*** to the address below:

DHHS Accounts Receivable
Division of Medical Assistance
325 N. Salisbury Street
2022 Mail Service Center
Raleigh, NC 27699–2022

DMA FQHC/RHC MEDICAID SCHEDULES
INSTRUCTIONS

After completing all schedules, print and complete the Certification Form as instructed below:

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 cost reporting forms, please contact Misty Bryant at (919) 647-8064 or e-mail misty.bryant@ncmail.net for FQHC's or contact Jason Hockaday at (919) 647-8087 or e-mail jason.hockaday@ncmail.net for RHC's.

DMA FQHC/RHC
MEDICAID COST REPORT
CHECKLIST

The following information **must** be submitted **along with your original Medicaid FQHC\RHC cost report**:

_____ A copy of your facility Medicare cost report.

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

_____ Supporting documentation and working papers including calculation of costs for the Medicare cost report.

_____ Supporting documentation and working papers including calculation of costs for the Medicaid cost report.

_____ Defined chart of account.

_____ Log of bad debts, if applicable.

_____ Financial Statements, audited or unaudited, at time of submission.