DIVISION OF MEDICAL ASSISTANCE

INTRUCTIONS FOR
SCHOOL BASED SERVICES (LEAs)
Quarterly Cost Report for the Reporting Periods
July 1, 2009 through June 30, 2010

Reporting Deadline: **March 1, 2011**

MAILING ADDRESS
DHHS-DIVISION OF MEDICAL ASSISTANCE
FINANCE MANAGEMENT
ATTN: TAMECA BOWE
2501 MAIL SERVICE CENTER
RALEIGH, NC 27699 - 2501

OVERNIGHT / EXPRESS MAIL ADDRESS
DHHS-DIVISION OF MEDICAL ASSISTANCE
FINANCE MANAGEMENT
ATTN: TAMECA BOWE
1985 UMSTEAD DRIVE
RALEIGH, NC 27603

North Carolina Medicaid Services in Schools - List of Eligible Practitioners

Category of Service	CFR Reference	Social Security Act, Section 1905 Reference	Provider Types	Licensure/Certification Authority
Audiology and Hearing Services	42 CFR §440.110(c)(3)	§1905(a)(11), physical therapy and related services	Qualified audiologist licensed by the state	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Speech Language Services	42 CFR §440.110(c)(1)	§1905(a)(11), physical therapy and related services	Qualified Speech/Language Pathologist licensed by the state	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Speech Language Services			Qualified Speech/Language Assistant under the direction of Licensed Speech Language Pathologist	North Carolina State Board of Examiners for Speech-Language Pathology and Audiology
Occupational Therapy	42 CFR §440.110(b)	§1905(a)(11), physical therapy and related services	Qualified occupational therapist licensed by the state	North Carolina Board of Occupational Therapy
Occupational Therapy			Qualified Occupational Therapy Assistant licensed by the state and under the direction of Licensed Occupational Therapist	North Carolina Board of Occupational Therapy
Physical Therapy	42 CFR §440.110(a)	§1905(a)(11), physical therapy and related services	Qualified physical therapist licensed by the state	North Carolina Board of Physical Therapy
Physical Therapy			Qualified Physical Therapy Assistant licensed by the state and under the direction of Licensed physical therapist	North Carolina Board of Physical Therapy
Psychological/ Counseling Services	42 CFR §440.60	§1905(a)(6), medical care, or any other type of remedial care	licensure as a practicing psychologist or psychological associate working under the direction of Licensed practicing psychologist	North Carolina State Board of Examiners of Practicing Psychologists
Psychological/ Counseling Services			licensure as a school psychologist	North Carolina Department of Public Instruction
Psychological/ Counseling Services			licensure as a Clinical Social Worker	North Carolina Certification and Licensing Board for Social Work
Nursing Services	42 CFR §440.60	§1905(a)(6), medical care, or any other type of remedial care	licensure as a Registered Nurse or Licensed Practical Nurse. Delegated staff are school or contracted staff such as teachers, teacher assistants, therapists, school administrators, administrative staff, cafeteria staff or personal care aides.	North Carolina Board of Nursing
Nursing Services	42 CFR §440.130			

INSTRUCTIONS FOR COMPLETING THE 2009-2010 SCHOOL BASED SERVICES COST REPORT

General

Cost reports must be prepared and completed by each LEA on a quarterly basis to reflect the time study results for the quarter in which costs were incurred. On an annual basis, each provider will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share.

For the cost report to be accurate, only fill in the shaded areas of the cost report. **Also, please be sure to fill in your signature, title, date and contact number at the bottom of Exhibit 1**.

Exhibit 1 - Final Certification Statement

For Exhibit 1 & 1A, all that is needed is to verify the information is correct in Section 1. Each of the section's information below will automatically fill in from other pages as they are completed. Exhibit 1A should be filed with each quarterly cost report. Exhibit 1 should only be filed with the year end cost report, compiled of all four quarterly cost reports, and should illustrate the certified combined costs from all four quarters of the state fiscal year.

1. The **Government Agency Name** and the **Address** field will automatically fill in as **Exhibit 2** is completed.

2. The **Reporting Period** field will automatically fill in after **Exhibit 2** has been completed.

3a. Verify that all information in the **Total Computable Expenditure by Type** are accurate based on totals on **Line 14 of Exhibit 9**.

3b. The **Year Ended** dates will automatically fill in as **Exhibit 2** is completed.

Exhibit 2 - Provider Data

Column B, Line 10: Enter the **Provider Name**.

Column B, Line 11: You must enter your **Medicaid Provider Number** as assigned by the NC Division of Medical Assistance. If the Medicaid Provider Number changed during the cost report period, please provide the prior Medicaid provider number.

Column B, Line 17: Enter the **County & State**.

Column B, Line 19: Enter the **name** of the **Business Manager/Finance Director**.

Column B, Line 21: Enter the **cost report preparer's name**. This should be the contact person if there are questions about the cost report.

Cost Report Line Number	**Description**

Exhibit 2 - Provider Data-Continuation

Column B, Line 23:	Enter the **contact phone number** for the person who completes the cost report or person in charge of the cost report.
Column B, Line 25:	Enter a **contact email address or website**.
Column B, Line 27-28:	Enter a **contact address**.
Column B, Line 29:	Enter the **city, state, and zip code**. *(Ex. Anytown, NC 27610)*
Column B, Line 34:	Enter the **Type of Time Study** that was conducted. *(Ex. Traditional or Random Moment)*
Column B, Line 36:	Enter the **time period the time study was conducted** that used to complete the cost report. *(Ex. If the time study information used for the cost reporting period was only for the first quarter of 2009, enter 1/1/2009 – 3/31/2009)*
Column B, Line 41:	Enter the current year's **Unrestricted Indirect Cost Rate**, which must cover the same period of time as the cost report period.
Column B, Line 43:	Enter the name of the **Cognizant Agency.** *(The cognizant agency that determines the Unrestricted Indirect Cost Rate is the NC Department of Public Instruction.)*
Column B, Line 45:	Enter the **Period of Time** for which the Unrestricted Indirect Cost Rate was approved for. *(Ex. 7/1/09-9/30/09)*
Column B, Line 47:	Enter the **Date** in which the Unrestricted Indirect Cost Rate was approved. *(Ex. 7/1/09)*

Exhibit 3 - Allocation Statistics

Line 15:	Enter the **total number of Medicaid students** covered.
Line 16:	Enter the **total number of students in the district** during the applicable period.
Line 17:	**Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Exhibit 4B.**
Line 22:	Enter the **total number of Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) students receiving services** (do not include managed care students).
Line 23:	Enter the **Total number of IEP Students OR IFSP Students.**
Line 24:	**Do not enter information into this column, this column is automatically calculated. The percentage calculated will carry over to Exhibits 4A and 4C.**

Exhibits 4A - Summary of Cost by Discipline for Direct Medical Services

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3, 5, 6B and 6D are completed.

Exhibits 4B - Summary of Cost by Discipline for Administrative Activities

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3, 5, 6B, 6D and 8 are completed.

Exhibits 4C - Summary of Other Non-Personnel Direct Medical Cost

Do not enter any information on this spreadsheet. This spreadsheet will automatically populate when Exhibits 2, 3 and 7 are completed.

Exhibit 5 - Time Study Results

Column D: Enter the **percentages calculated** from the completed time study for each field. **Enter the percentage in decimal form.** *(Ex. If the percentage from the time study for Direct Medical Services Covered is 23.57%, enter .2357 in Column D)*

The percentage calculated in cell F31 will carry to Exhibit 4A and the percentage calculated in cell I31 will carry to Exhibit 4B.

Exhibit 6A & 6B - Direct Cost by Discipline

For each type of service, enter all the required information as you move across the rows. Also, be sure to enter your Accrual Trial Balance totals along the top line of each discipline. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Exhibits 4A and 4B.

Column B: Enter the vendor's/employee's **Position Number or Employee ID.**

Column C: Enter the vendor's/employee's **last name.**

Column D: Enter the vendor's/employee's **first name.**

Column E: Enter the vendor's/employee's **job title.**

Column F: Enter who performed the services. ***(Enter either Vendor or Employee)***

Column G: Enter the vendor's/employee's **total gross salary.**

Cost Report
Line Number **Description**

Exhibit 6A & 6B - Direct Cost by Discipline-Continuation

Column H: Enter whether or not the vendor's/employee's salary is **fully funded** by a Federal grant payment(s). (***Enter either Yes or No)*** **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column I.**

Column I: **Do not enter information into this column, this column is automatically calculated.**

Column J: Enter whether or not the vendor's/employee's salary is **partially funded** by a Federal grant payment(s). ***(Enter either Yes or No***) **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Column K: Enter the amount of **Federally Funded salary**.

Column L: Enter the amount of **State Matched salary.**

Column M: Enter any other **reductions to the total gross salary.**

Column N: **Do not enter information into this column, this column is automatically calculated.**

Column O: Enter the amount of the **employee benefits paid** to the employee.

Column P: Enter the amount of the **employee FICA tax paid** (if not covered under employee benefits).

Column Q: Enter the amount of the **employee Medicare tax paid** (if not listed under employee benefits).

Column R: Enter the amount of **Vendor/Contractor payments**.

Column S: **Do not enter information into this column, this column is automatically calculated.**

Cost Report
Line Number **Description**

Exhibit 6C & 6D - Direct Cost by Discipline - Continuation

For each type of service, enter all the required information as you move across the rows. Also, be sure to enter your Accrual Trial Balance totals along the top line of each discipline. The total Adjusted Salary & Benefits and Vendor Payments for each discipline will carry to Exhibits 4A and 4B.

Column B: Enter the vendor's/employee's **Position Number or Employee ID.**

Column C: Enter the vendor's/employee's **last name.**

Column D: Enter the vendor's/employee's **first name.**

Column E: Enter the vendor's/employee's **job title.**

Column F: Enter who performed the services. ***(Enter either Vendor or Employee)***

Column G: Enter the vendor's/employee's **total gross salary.**

Column H: Enter whether or not the vendor/employee is **fully funded** by a Federal grant. ***(Enter either Yes or No)*** **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column I.**

Column I: **Do not enter information into this column, this column is automatically calculated.**

Column J: Enter whether or not the vendor/employee is **partially funded** by a Federal Funds. ***(Enter either Yes or No)*** **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Column K: Enter the amount of **Federally Funded salary**.

Column L: Enter the amount of **State Matched salary.**

Column M: Enter any other **reductions to the total gross salary.**

Column N: **Do not enter information into this column, this column is automatically calculated.**

Column O: Enter the amount of the **employee benefits paid** to the employee.

Column P: Enter the amount of the **employee FICA tax paid** (if not covered under employee benefits).

Exhibit 6C & 6D - Direct Cost by Discipline – Continuation

Column Q: Enter the amount of the **employee Medicare tax paid** (if not listed under employee benefits).

Column R: Enter the amount of **Vendor/Contractor payments**.

Column S: **Do not enter information into this column, this column is automatically calculated.**

Exhibit 7 - Other Non-Personnel Direct Medical Cost

For each discipline, enter all the required information as you move across each row. Also, be sure to enter your Accrual Trial Balance totals along the top line of each account type. The Adjusted Trial Balance totals will carry to Exhibit 4C.

Column B: Enter the **trial balance account number.**

Column C: Enter the **trial balance account description.**

Column F: Enter the **trial balance amount.**

Column G: Enter whether or not the cost is **fully funded** by a Federal grant payment(s) ***(Enter either Yes or No*****). Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column H.**

Column H: **Do not enter information into this column, this column is automatically calculated.**

Column I: Enter whether or not the cost is **partially funded** by a Federal grant payment(s). **(*Enter either Yes or No.)* Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Column J: Enter the amount of **Federally Funded cost.**

Column K: Enter the amount of **State Matched cost.**

Column L: Enter any other **reductions to the trial balance**.

Column M: **Do not enter information into this column, this column is automatically calculated.**

Cost Report
Line Number **Description**

Exhibit 8 - Other Cost for Medicaid Administrative Claiming Plan Activities

For each discipline, enter all the required information as you move across each row. Also, be sure to enter your Accrual Trial Balance totals along the top line of each account type. The Adjusted Trial Balance totals will carry to Exhibit 4B.

Column B: Enter the **trial balance account number.**

Column C: Enter the **trial balance account description.**

Column F: Enter the **trial balance amount.**

Column G: Enter whether or not the cost is **fully funded** by a Federal grant payment(s). ***(Enter either Yes or No)*** **Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services. This amount will automatically calculate column H.**

Column H: **Do not enter information into this column, this column is automatically calculated.**

Column I: Enter whether or not the cost is **partially funded** by a Federal grant payment(s). **Enter Yes or No) Total direct costs for direct medical services are reduced by any federal grant payments with a matching requirement resulting in adjusted direct costs for direct medical services.**

Column J: Enter the amount of **Federally Funded cost.**

Column K: Enter the amount of **State Matched cost.**

Column L: Enter any other **reductions to the trial balance.**

Column M: **Do not enter information into this column, this column is automatically calculated**.

Exhibit 9 - Reconciliation and Settlement

Line 18: Enter the **Total Medical Claims paid.**

Line 19: Enter the **Total Administrative Claims paid.**

Column D, Line 35: Enter the **Medical Federal Financial Participation percentage** for the previous year.

Column D, Line 36: Enter the **Administrative Federal Financial Participation percentage** for the previous year.

Column E, Line 35: Enter the **Medical Federal Financial Participation percentage** for the current year.

Column E, Line 36: Enter the **Administrative Federal Financial Participation percentage** for the current year.

When providers file a cost report indicating that an overpayment has occurred, **FULL REFUND** is to be remitted with the report to DHHS Accounts Receivable. This refund should be mailed under separate cover to:

Send Via US Mail To:
DHHS Accounts Receivable
Division of Medical Assistance
2022 Mail Service Center
Raleigh, NC 27699-2022