

State of Oregon  
 Department of Human Resources  
 Division of Medical Assistance Programs

**COST STATEMENT**  
 Federally Qualified Health Centers (FQHC)  
 Rural Health Clinics (RHC)

***This Box  
 For DMAP  
 Use Only***

Initial report not reviewed  
 Revised by FQHC/RHC  
 Desk review  
 Audited  
 Reopen

|              |                  |
|--------------|------------------|
| HC Name:     | HC Phone Number: |
| HC Address:  | City/State ZIP   |
| HC Owned By: |                  |

|                     |  |
|---------------------|--|
| HC Provider Number: | <b>Reporting Period</b><br>Fiscal Year Period: |
|---------------------|--|

List all other FQHCs or RHCs, medical practitioners, providers of service including hospitals, skilled nursing facilities, home health agencies, suppliers or other entities that are owned or related through common ownership or control to the HC Provider Number listed above. Include their locations and their DMAP provider numbers.

| Provider Name | Location | Provider Number |
|---------------|----------|-----------------|
|               |          |                 |
|               |          |                 |
|               |          |                 |
|               |          |                 |
|               |          |                 |
|               |          |                 |
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|               |          |                 |
|               |          |                 |
|               |          |                 |

List the names of all physicians and other health care practitioners furnishing services to, or under agreement with, the FQHC or RHC identified by the HC Provider Number listed above. Include their individual DMAP Provider Numbers.

| Health Care Practitioner | Provider Number |
|--------------------------|-----------------|
|                          |                 |
|                          |                 |
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|                          |                 |

Under penalties of perjury, I declare that I have examined this Cost Statement, including accompanying schedules and statements, and to the best of my knowledge and belief, it is true, correct and complete as prepared from the books and records of the FQHC or RHC in accordance with the instructions for preparing the DMAP form 3027.

|                        |      |                                 |      |
|------------------------|------|---------------------------------|------|
| Accountant's Signature | Date | Responsible Officer's Signature | Date |
|------------------------|------|---------------------------------|------|

|  |                     |   |
|--|---------------------|---|
| <b>COST STATEMENT</b><br>Federally Qualified Health Centers (FQHC)<br>Rural Health Clinics (RHC) | HC Name:            | 0 |
|  | HC Number:          | 0 |
|  | Fiscal Year Period: | 0 |

**Part A FQHC or RHC Practitioner Staff and Visits**

| Positions   | FTE Personnel        |            |            | Encounters   |               |            |
|---|----------------------|------------|------------|--------------|---------------|------------|
|   | Under Agreement<br>1 | Staff<br>2 | Total<br>3 | On Site<br>4 | Off Site<br>5 | Total<br>6 |
| 1. Physicians                                       |                      |            | 0.0        |              |               | 0          |
| 2. Midlevels  |                      |            | 0.0        |              |               | 0          |
| 3. Visiting Nurses                                  |                      |            | 0.0        |              |               | 0          |
| 4. Nurses (RN, LPN, LVN)                            |                      |            | 0.0        |              |               | 0          |
| <b>5. Subtotal</b>                                  | 0.0                  | 0.0        | 0.0        | 0            | 0             | 0          |
| 6. Psychiatrists                                    |                      |            | 0.0        |              |               | 0          |
| 7. Dentists   |                      |            | 0.0        |              |               | 0          |
| 8. Hygienist  |                      |            | 0.0        |              |               | 0          |
| 9. Therapists                                       |                      |            | 0.0        |              |               | 0          |
| 10. Social Workers                                  |                      |            | 0.0        |              |               | 0          |
| 11. Psychologists                                   |                      |            | 0.0        |              |               | 0          |
| 12. Optometrists                                    |                      |            | 0.0        |              |               | 0          |
| 13. Nutritionists                                   |                      |            | 0.0        |              |               | 0          |
| 14. Audiologists                                    |                      |            | 0.0        |              |               | 0          |
| 15. Administration                                  |                      |            | 0.0        |              |               | 0          |
| 16. Outstationed Eligibility Workers                |                      |            | 0.0        |              |               | 0*         |
| 17. Other (Specify)                                 |                      |            | 0.0        |              |               | 0          |
| 18.   |                      |            | 0.0        |              |               | 0          |
| 19.   |                      |            | 0.0        |              |               | 0          |
| <b>20. Total (Should equal total FTE in clinic)</b> | 0.0                  | 0.0        | 0.0        | 0            | 0             | 0          |

For reimbursement purposes, Full Time Equivalent (FTE) is defined as the total number of paid hours for the year divided by 2080. Cols 1, 2 and 3 of Part A show the total FTEs for each class of practitioner. Col. 3, Line A-20 shows the total of all FTEs for all practitioners in the facility.

\* Enter the number of applications processed.

|  |                     |   |
|--|---------------------|---|
| <b>COST STATEMENT</b><br>Federally Qualified Health Centers (FQHC)<br>Rural Health Clinics (RHC) | HC Name:            | 0 |
|  | HC Provider Number: | 0 |
|  | Fiscal Year Period: | 0 |

| <b>Reclassification and Adjustment of Trial Balance Expenses</b> |              |                   |                              |                  |       |                  |                               |                         |
|--|--------------|-------------------|------------------------------|------------------|-------|------------------|-------------------------------|-------------------------|
| Cost Center  | Compensation | Employee Benefits | Purchased & Contracted Svcs. | Medical Supplies | Other | Total (Col. 1-5) | Reclassification/ Adjustments | Net Expenses (Col. 6-7) |
|  | 1            | 2                 | 3                            | 4                | 5     | 6                | 7                             | 8                       |
| 1. Medical   |              |                   |                              |                  |       | 0                |                               | 0                       |
| 2. Laboratory-Medical  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 3. X-Ray Medical   |              |                   |                              |                  |       | 0                |                               | 0                       |
| 4. Pharmacy  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 5. Dental  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 6. Speech and Hearing  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 7. Occupational Therapy  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 8. Physical Therapy  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 9. Optometry   |              |                   |                              |                  |       | 0                |                               | 0                       |
| 10. Podiatry   |              |                   |                              |                  |       | 0                |                               | 0                       |
| 11. Medical Social Services                                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| 12. Clinical Psychology  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 13. Mental Health  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 14. Family Planning  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 15. Patient Transportation                                       |              |                   |                              |                  |       | 0                |                               | 0                       |
| 16. Durable Medical Equipment                                    |              |                   |                              |                  |       | 0                |                               | 0                       |
| 17. Other: (Specify)   |              |                   |                              |                  |       | 0                |                               | 0                       |
| 18.  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 19.  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 20.  |              |                   |                              |                  |       | 0                |                               | 0                       |
| <b>21. Total (Sum lines 1-20)</b>                                | 0            | 0                 | 0                            | 0                | 0     | 0                | 0                             | 0                       |

| <b>Non-Reimbursable Program Costs</b> |   |   |   |   |   |   |   |   |
|---------------------------------------|---|---|---|---|---|---|---|---|
| 22. Women Infants & Children (WIC)    |   |   |   |   |   |   |   | 0 |
| 23. Community Services/Housing Proj.  |   |   |   |   |   |   |   | 0 |
| 24. Environmental/Pesticide           |   |   |   |   |   |   |   | 0 |
| 25. Research                          |   |   |   |   |   |   |   | 0 |
| 26. Outside Services                  |   |   |   |   |   |   |   | 0 |
| 27. Public Education                  |   |   |   |   |   |   |   | 0 |
| 28. Other (Specify)                   |   |   |   |   |   |   |   | 0 |
| <b>29. Total (Sum lines 22-28)</b>    | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Cost Center                              | Compensation | Employee Benefits | Purchased & Contracted Svcs. | Medical Supplies | Other | Total (Col. 1-5) | Reclassification/ Adjustments | Net Expenses (Col. 6-7) |
|--|--------------|-------------------|------------------------------|------------------|-------|------------------|-------------------------------|-------------------------|
|  | 1            | 2                 | 3                            | 4                | 5     | 6                | 7                             | 8                       |
| <b>Allowable Overhead Costs</b>          |              |                   |                              |                  |       |                  |                               |                         |
| 30. Administration                       |              |                   |                              |                  |       | 0                |                               | 0                       |
| 31. Financial and Legal                  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 32. Supplies                             |              |                   |                              |                  |       | 0                |                               | 0                       |
| 33. Insurance                            |              |                   |                              |                  |       | 0                |                               | 0                       |
| 34. Telephone                            |              |                   |                              |                  |       | 0                |                               | 0                       |
| 35. Utilities                            |              |                   |                              |                  |       | 0                |                               | 0                       |
| 36. Rent                                 |              |                   |                              |                  |       | 0                |                               | 0                       |
| 37. Maintenance and Repair               |              |                   |                              |                  |       | 0                |                               | 0                       |
| 38. Depreciation                         |              |                   |                              |                  |       | 0                |                               | 0                       |
| 39. Amortization                         |              |                   |                              |                  |       | 0                |                               | 0                       |
| 40. Transportation                       |              |                   |                              |                  |       | 0                |                               | 0                       |
| 41. Mortgage Interest                    |              |                   |                              |                  |       | 0                |                               | 0                       |
| 42. Travel                               |              |                   |                              |                  |       | 0                |                               | 0                       |
| 43. Staff Training                       |              |                   |                              |                  |       | 0                |                               | 0                       |
| 44. Other (Specify)                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| 45.                                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| <b>46. Subtotal (Sum lines 30-45)</b>    | 0            | 0                 | 0                            | 0                | 0     | 0                | 0                             | 0                       |
| 47. Outstationed Eligibility Workers     |              |                   |                              |                  |       | 0                |                               | 0                       |
| <b>48. Total (Sum lines 46-47)</b>       | 0            | 0                 | 0                            | 0                | 0     | 0                | 0                             | 0                       |
| <b>Non-Reimbursable Overhead Costs</b>   |              |                   |                              |                  |       |                  |                               |                         |
| 49. Entertainment                        |              |                   |                              |                  |       | 0                |                               | 0                       |
| 50. Fines and Penalties                  |              |                   |                              |                  |       | 0                |                               | 0                       |
| 51. Fund-raising                         |              |                   |                              |                  |       | 0                |                               | 0                       |
| 52. Goodwill                             |              |                   |                              |                  |       | 0                |                               | 0                       |
| 53. Gifts and Contributions              |              |                   |                              |                  |       | 0                |                               | 0                       |
| 54. Political Contributions              |              |                   |                              |                  |       | 0                |                               | 0                       |
| 55. Bad Debts                            |              |                   |                              |                  |       | 0                |                               | 0                       |
| 56. Other Interest Expense               |              |                   |                              |                  |       | 0                |                               | 0                       |
| 57. Advertising                          |              |                   |                              |                  |       | 0                |                               | 0                       |
| 58.                                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| 59.                                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| 60. Other (Specify)                      |              |                   |                              |                  |       | 0                |                               | 0                       |
| <b>61. Total (Sum lines 49-60)</b>       | 0            | 0                 | 0                            | 0                | 0     | 0                | 0                             | 0                       |
| <b>Total Costs</b>                       |              |                   |                              |                  |       |                  |                               |                         |
| <b>62. Total (Sum lines 21,29,48,61)</b> | 0            | 0                 | 0                            | 0                | 0     | 0                | 0                             | 0                       |

|  |                       |
|--|-----------------------|
| <b>COST STATEMENT</b><br>Federally Qualified Health Centers (FQHC)<br>Rural Health Clinics (RHC) | HC Name: 0            |
|  | HC Number: 0          |
|  | Fiscal Year Period: 0 |

| PART A | Determination Of Overhead Applicable To FQHC & RHC Services                                  | Amount  |
|--------|--|---------|
|        | 1. Total cost of FQHC or RHC services excluding overhead (Page 3, column 8, line 21)         | \$0     |
|        | 2. Non-reimbursable program costs excluding overhead (Page 3, column 8, line 29)             | \$0     |
|        | 3. Total costs excluding overhead (Sum of lines A1 plus line A2)                             | \$0     |
|        | 4. Percentage of non-reimbursable FQHC or RHC costs (Line A2 divided by line A3)             | #DIV/0! |
|        | 5. Total allowable overhead costs excluding eligibility services (Page 4, column 8, line 46) | \$0     |
|        | 6. Overhead applicable to non-reimbursable FQHC or RHC costs (Line A4 times line A5)         | #DIV/0! |
|        | 7. Overhead applicable to allowable FQHC or RHC costs (Line A5 less line A6)                 | #DIV/0! |
|        | 8. Total cost of FQHC or RHC services (Line A1 plus line A7)                                 | #DIV/0! |

| PART B-1 | Determination Of Rate - For FQHC  | FQHC Rate |
|----------|---|-----------|
|          | 1. Total FQHC cost (excluding outstationed eligibility worker cost) (Line A8) | #DIV/0!   |
|          | 2. Total FQHC encounters (Page 2, column 6, line 20)                          | 0         |
|          | 3. FQHC rate per encounter (Line B1-1 divided by line B1-2)                   | #DIV/0!   |

| PART B-2 | Determination Of Rate - For RHC                            | RHC Rate |
|----------|--|----------|
|          | 1. Total RHC cost (Line A8)                                | #DIV/0!  |
|          | 2. Total RHC Encounters (Page 2, column 6, line 20)        | 0        |
|          | 3. RHC Rate per encounter (Line B2-1 divided by line B2-2) | #DIV/0!  |

| PART C | Determination Of Outstationed Eligibility Worker Rate (FQHC Only)                         | Amount  |
|--------|---|---------|
|        | 1. Cost of outstationed eligibility worker(s) (Page 4, column 8, line 47)                 | \$0     |
|        | 2. Total FQHC Medicaid encounters Per DMAP report   | \$0     |
|        | 3. Rate per encounter for outstationed eligibility worker(s) (Line C1 divided by line C2) | #DIV/0! |
|        | 4. Total rate per encounter (Line B1-3 plus line C3)                                      | #DIV/0! |

**COST STATEMENT (DMAP 3027) Instructions**  
**Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC)**

The DMAP 3027 is a required form for Federally Qualified Health Center (FQHC) reimbursement. Rural Health Clinics (RHC) have a choice of either submitting their Medicare Cost Report or DMAP 3027. If the RHC files a Medicare Cost Report, additional data may be requested by the Division of Medical Assistance Programs (DMAP).

Reimbursement is based upon the actual reasonable allowable cost per encounter as defined in the Federally Qualified and Rural Health Centers Administrative Rules. The six-page form must be submitted to DMAP in the following circumstances: 1) During an adjustment to an established clinic's rate based on change of scope in services; 2) Prior to enrollment to determine an encounter rate for any new FQHC or RHC; or 3) At DMAP's request to verify appropriate encounter rates (see OAR 410-147-0360). If there is a change in ownership, the Cost Statement or Medicare Cost Report must be submitted within 30 days of change of ownership. The Cost Statement must include all documents required by OAR 410-147-0480.

(Each section must be completed if applicable)

**Page 1      Statistical Information**

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- a. Enter the full name of the FQHC or RHC, the address and telephone number, the fiscal reporting period, the DMAP provider number, and the name of the persons or organizations having legal ownership of the FQHC or RHC.
- b. List all other FQHCs or RHCs, medical practitioners, suppliers, or entities owned by the FQHC or RHC by DMAP provider number.
- c. List all physicians and health care practitioners furnishing services to the FQHC or RHC by the individual DMAP provider number.
- d. The Cost Statement (DMAP 3027) must be prepared and signed by the FQHC or RHC accountant and an authorized responsible officer.

**Page 2      Part A - FQHC or RHC Practitioner Staff and Visits**

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- a. FTE Personnel: List the total number of staff by position and enter a total on Line 20.
- b. Encounters: List the number of on-site and off-site encounters by staff and enter a total on Line 20.

**Pages 3 - 4    Reclassification and Adjustment of Trial Balance of Expenses**

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*Covered Health Care Costs, Non-Reimbursable Program Costs, Allowable Overhead Costs and Non-Reimbursable Overhead Costs:*

- a. Record the expenses for covered medical costs, non-reimbursable program costs, allowable overhead costs, and non-reimbursable overhead costs provided by cost centers in columns 1 - 5 and enter the totals in column 6. (Attach expense documentation from financial accounting records and an explanation for allocations, and the allocation method used.)
- b. Enter any reclassified expenses, adjustments (increase/decrease) of actual expenses in accordance with the FQHC and RHC administrative rules on allowable costs in column 7. Attach documentation/explanation.
- c. Enter the combined reclassified trial balance with the amount of adjustment in column 8.
- d. Enter the totals from each column under Covered Medical Costs on line 21.  
Enter the totals from each column under Non-Reimbursable Program Costs on line 29.  
Enter the totals from each column under Allowable Overhead Costs on line 48.  
Enter the totals from each column under Non-Reimbursable Overhead Costs on line 61.  
Enter the combined totals from lines 21, 29, 48 and 61 on line 62.

**Page 5      Determinations**

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*Determination of Overhead Applicable to FQHC and RHC Services.*

- a. Part A and B: Enter all totals from the previous pages of the Cost Statement as requested under overhead applicable to FQHC or RHC services and FQHC or RHC rate.
- b. Part C: For FQHCs only. If applicable, complete by entering the wages for Outstationed Eligibility Workers on line C1, divide the wages by the number of billable Medical Assistance Program encounters to determine the rate per encounter.

Administrative Rule 410-147-0480.