

## 5101:3-2-23 Cost reports.

(A) For cost-reporting purposes, the medicaid program requires each eligible provider, as defined in rule 5101:3-2-01 of the Administrative Code, to submit periodic reports that generally cover a consecutive twelve-month period of the provider's operations. ~~Cost reports must be filed within one hundred eighty days of the end of the hospital's cost-reporting year. Extensions of this one hundred eighty day period shall be granted if the centers for medicare and medicaid services (CMS) of the United States department of health and human services extends the date by which the hospital must submit its cost report for the hospital's cost-reporting period.~~ Failure to submit all necessary items and schedules will only delay processing and may result in a reduction of payment or termination as a provider as described in paragraph (H) of this rule.

Effective for medicaid cost reports filed for cost-reporting periods ending in state fiscal year (SFY) 2003, and each cost-reporting period thereafter, any hospital that fails to submit cost reports on or before the dates specified by ODJFS shall be fined one thousand dollars for each day after the due date that the information is not reported.

The hospital shall complete and submit the JFS 02930 "Hospital Cost Report" in accordance with instructions contained in this rule. The JFS 02930 (rev. 4/2009~~2010~~) for SFY 2009~~2010~~ and its instructions are shown in the appendix to this rule. The hospital's cost report must:

- (1) Be prepared in accordance with medicare principles governing reasonable cost reimbursement set forth in the providers' reimbursement manual "CMS Publications 15, 15-1 and 15-2," available at <http://www.cms.hhs.gov/Manuals/PBM/list.asp#TopOfPage> dated September 8, 2005.
- (2) Include all information necessary for the proper determination of costs payable under medicaid, including financial records and statistical data.
- (3) Be submitted in accordance with the instructions in the appendix to this rule an electronic copy of the medicare cost report, which must be identical in all respects to the cost report submitted to the medicare fiscal intermediary.
- (4) Include the cost report certification executed by an officer of the hospital attesting to the accuracy of the cost report and to the accuracy of the OBRA survey. In addition, all subsequent revisions to the cost report must include an executed certification.
- (5) Effective for medicaid cost reports filed for cost-reporting periods ending in SFY 2003, and each cost-reporting period thereafter, the executed

NOV 29 2010

5101:3-2-23

2

certification shall require the officer of the hospital to acknowledge that an independent party, a certified public accountant, has successfully verified the data reported on "Schedule F" of the cost report in accordance with the procedures included in the cost report instructions. In addition, all subsequent revisions to "Schedule F" shall also be successfully verified by an independent, certified public accountant in accordance with the recertification procedures included in the cost report instructions.

(6) For hospital reporting periods ending between January first and June thirtieth the cost report is due by December thirty-first of the same calendar year. For hospital reporting periods ending between July first and December thirty-first, the cost report is due by June thirtieth of the following calendar year. Extensions may be granted as specified in the appendix to this rule.

- (B) Hospitals having a distinct part psychiatric or rehabilitation unit recognized by medicare in accordance with the provisions of 42 C.F.R. 412.25 effective October 1, 2006, 42 C.F.R. 412.27 effective July 1, 2006, and 42 C.F.R. 412.29 effective January 1, 2005, must identify distinct part unit costs separately within the cost report as described in paragraph (A) of this rule.
- (C) Ohio hospitals performing transplant services covered under medicaid as described in rule 5101:3-2-07.1 of the Administrative Code must identify transplant costs, charges, days, and discharges separately within the cost report as described in paragraph (A) of this rule.
- (D) Ohio hospitals performing ambulatory surgery within the hospital outpatient setting must identify ambulatory surgery costs and charges separately within the cost report as described in paragraph (A) of this rule.
- (E) Ohio hospitals providing services to medicaid managed care plan (MCP) enrollees must identify MCP costs, charges and payments separately within the cost report as described in paragraph (A) of this rule.
- (F) It is not necessary for the hospital to wait for the medicare (Title XVIII) audit in order to file the initial cost report for the stated time period. The interim cost report filing can be audited by the ODJFS prior to any applicable final adjustment and settlement. If an amount is due ODJFS as a result of the filing, payment must be forwarded, in accordance with the instructions in the appendix to this rule, at the time the cost report is submitted for it to be considered a complete filing. Any revised interim cost report must be received within thirty days of the provider's receipt of the interim cost settlement. A desk audit will be performed by the hospital audit section on all as filed and interim cost reports. An interim cost settlement by ODJFS does not preclude the finding of additional cost exceptions in a final settlement for the same cost-reporting period.

NOV 29 2010

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5101:3-2-23

3

- (1) If an amended medicare cost report is filed with the medicare fiscal intermediary, a copy of the amended medicare cost report must be filed with the hospital audit section. Information contained in the amended medicare cost report will be incorporated into the interim cost report, as originally filed, if received prior to interim settlement; otherwise, it is subject to the provisions of paragraph (F) of this rule.
  - (2) Adjustments may be made to the interim cost report as described in rule 5101:3-2-24 of the Administrative Code.
- (G) Out-of-state providers that are not paid on a prospective payment basis and provide inpatient and/or outpatient services to eligible Ohio Title XIX recipients will be required to file the cost report identified in this rule.
- (H) Hospitals that fail to submit cost reports timely as defined in paragraph (A) of this rule will receive a delinquency letter from the ODJFS and are subject to notification that thirty days following the date on which the cost report was due, payments for hospital services will be suspended. Suspension of payments will be terminated on the fifth working day following receipt of the delinquent cost report. Claims affected by suspension of payment are not considered to be clean claims as "clean claims" are defined in rule 5101:3-1-19.3 of the Administrative Code. At the beginning of the third month following the month in which the hospital cost report became overdue, if the cost report has not yet been submitted, termination of the provider from the program will be recommended in accordance with Chapter 5101:3-1 of the Administrative Code.

NOV 29 2010

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4

Effective:

R.C. 119.032 review dates: 09/01/2012

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Certification

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Date

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Appendix  
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Attachment 4.19 - A

Page 1 of 52

**Ohio Department of Job and Family Services**

**HOSPITAL COST REPORT (JFS 02930)**

**INSTRUCTIONS**

**For State Fiscal Year 2010**

NOV 29 2010

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SUPERSEDES

TN No. 09-027 Effective Date: 07-01-2010

**JFS 02930-I (Rev. 4/2010)**

APPENDIX pt64177) ppt114139) Jt292947) rnf240470)

## Table of Contents

GENERAL INSTRUCTIONS.....	3
FILING DEADLINE.....	3
REQUIRED FILINGS .....	3
FILING EXTENSIONS.....	4
AMENDED FILINGS .....	4
IMPORTANT REMINDERS .....	4
CHANGES .....	4
SCHEDULE A.....	5
SCHEDULE B.....	6
SCHEDULE C.....	8
SCHEDULE C-1.....	9
SCHEDULE C-2.....	11
SCHEDULE D .....	12
SCHEDULE D-1 .....	14
SCHEDULE E.....	15
SCHEDULE F.....	16
INDEPENDENT THIRD PARTY VALIDATION OF SCHEDULE F DATA.....	16
GENERAL INSTRUCTIONS (APPLIES TO ALL OF SECTION I).....	18
SECTION I (UNCOMPENSATED CARE FOR ACUTE CARE HOSPITALS).....	19
Instructions for Column 1.....	19
Instructions for Column 2.....	20
Instructions for Column 3.....	22
Instructions for Columns 4 and 5.....	22
Instructions for Column 6.....	22
Instructions for Column 7.....	24
SECTION II (FREE-STANDING PSYCHIATRIC HOSPITAL INFORMATION) .....	26
SCHEDULE G .....	28
SCHEDULE H .....	29
SCHEDULE I .....	32
Cost Report Schedules.....	34

NOV 29 2010

## GENERAL INSTRUCTIONS

Please read and follow all instructions carefully. *Instructions that pertain to DRG-exempt and out-of-state hospitals will be in italics throughout the cost report instructions.* If you have questions about the instructions or report please contact Jeff Runkle of the Rate Setting & Cost Settling Unit, (614) 752-4427.

The cost report schedules should be completed in order, from A to I. Within the report, the line numbers for the revenue centers are set up to closely match the CMS-2552-96 in order to allow for easy transfer of data.

UB-92 revenue center codes should be grouped as shown on the attached sheets for inpatient and outpatient services. If this is not possible **YOU MUST** specifically identify any differences in groupings on the enclosed **BILLING CODE ALLOCATION sheet(s)** and return them with the completed cost report. When differences in groupings exist but are not identified by the report filer, ODJFS groupings will be used at the time of settlement.

Report only data and discharges occurring within the fiscal period covered by this cost report.

### FILING DEADLINE

Rule 5101:3-2-09, of the Ohio Administrative Code states in part "...any hospital that fails to report the information required under this rule on or before the dates specified in this rule and in rule 5101:3-2-23 of the administrative code shall be fined one thousand dollars (\$1,000.00) for each day after the due date that the information is not reported."

**The completed cost report MUST BE POSTMARKED on or before June 30, 2010 for those hospitals filing with a cost reporting period ending between July 1, 2009 and December 31, 2009. For those hospitals filing with a cost report period ending between January 1, 2010 and June 30, 2010, the report is to be postmarked no later than December 31, 2010.**

### REQUIRED FILINGS

Your completed cost report filing **MUST** include:

- the completed CMS-2552-96 electronic cost report (EC) and print image (PI) files
- all completed applicable JFS 02930 schedules
- **Email** the CMS-2552-96 (EC & PI files) and JFS 02930.xls to:  
hospital\_cost\_reports@jfs.ohio.gov  
If unable to email, please contact ODJFS.
- **Mail the following cost report information to:**

<b>Via Regular Mail (preferred)</b> Ohio Health Plans Rate Setting & Cost Settling Unit P.O. Box 182709 Columbus, OH 43218-2709	<b>Via Parcel Carriers (not required)</b> Ohio Health Plans Rate Setting & Cost Settling Unit 50 W. Town Street, Ste 400, 4 <sup>th</sup> Floor Columbus, OH 43215-4142
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An original SIGNED JFS 02930 Certification Page  
 A hard copy of the JFS 02930 schedules and OBRA Survey  
 A copy of the SIGNED CMS-2552-96 Certification Page

- **Remittance for amounts due with copy of settlement page should be mailed to:**  
**Ohio Department of Job and Family Services**  
**P.O. Box 182367, Columbus, OH 43218-2367**
- Make checks payable to: Treasurer of State, State of Ohio (ODJFS)

NOV 29 2010

**Incomplete filings are subject to the \$1,000 per day fine described above.**

### **FILING EXTENSIONS**

Requests for an extension of the filing deadline, for no more than one 30 day period, must be made in advance, in writing, to **Ohio Health Plans, Cost Reporting Unit, P.O. Box 182709, Columbus, OH 43218-2709.**

If Medicare grants an extension that would go beyond the above one-time 30 day extension, documentation must be provided. Please submit your request in writing to the above address and include a copy of the Medicare extension letter. The filing deadline will be 30 days after the required filing date of the Medicare Cost Report. No further extensions will be granted.

### **AMENDED FILINGS**

Amended CMS-2552-96 reports filed by hospitals with the Medicare Intermediary must also be filed with ODJFS. No amendments to the JFS 02930 will be accepted later than 30 days after the hospital's receipt of the audited interim settlement.

### **IMPORTANT REMINDERS**

**The Upper Limit Payments (UPL) payments reported on Schedule H, col. 1, line 5 should be recorded gross, not net.**

**The OBRA Survey must be completed in its entirety.**

**Out-of-State providers that are paid on a prospective payment basis are NOT required to file a cost report.**

**Hospitals are provided with Interim Paid Claims data indicating paid Medicaid Fee-for-Service claims through the date specified on the report. This information is provided as a courtesy to hospitals. Each hospital is expected to use its own accounting/patient information system to complete the cost report.**

### **CHANGES**

- **The cost report instructions and forms have been updated to reflect dates and filing deadlines relevant to the SFY 2010 Reporting Periods.**
- **Text has been added to Schedules D and I to provide guidance on when claim charges should be included on those schedules.**

NOV 29 2010

## SCHEDULE A

### MISCELLANEOUS REVENUES

**Note - Throughout the JFS 02930 cost report instructions "Worksheet" refers to Medicare's CMS-2552-96 and "Schedule" refers to the JFS 02930.**

**Lines 1 - 24 - Enter all amounts included on Worksheet G-2 which are not included on the Worksheet C, column 8. Examples may include, but are not limited to: Home Health, Hospice, Organ Acquisition, Professional Fees (detailed by cost center), etc.**

## SCHEDULE B

## COST DISTRIBUTION

**Column 1**

**Lines 25-34, 37-97, and 100** - Enter total cost figures from Worksheet C, Part I, column 5 for each revenue center. **Note: Report costs for Organ Acquisition, Hospice, and Home Health Agency from Worksheet B, part I, column 27. For free-standing psychiatric hospitals, do not report costs associated with residential treatment.**

**Line 100** - Enter Observation Bed costs only if these costs are included both on line 25 and on line 62.

**Column 2**

**Lines 25-34 and 37-97** - Enter all Interns and Residents costs that were removed from total cost reported on Worksheet B part I, column 26. Include drug costs related to Renal Dialysis or Home Program Dialysis that were also removed from total costs.

**Column 3**

**Lines 25 - 97** - Enter the total of columns 1 and 2.

**Column 4**

**For any revenue center that has costs but no corresponding charges, enter a charge of one dollar (\$1.00).**

**Lines 25-97** - Record total charges from Worksheet C, part I, column 8.

**Line 100** - Enter one dollar (\$1.00) if an amount is entered in column 3, line 100.

**Column 5**

**Lines 25-34, 37-97, and 100** - Divide each line amount in column 3 by the corresponding line amount in column 4 and enter the result rounded to six decimal places.

**Column 6**

**Lines 25-34 and 37-97** - Enter the total allowable inpatient charges from Worksheet C, part I, column 6 for each revenue center. (Note: Subprovider services reimbursed on a cost basis by Medicare but reimbursed by Medicaid on the DRG system must be included in this column; i.e., Distinct Part Psychiatric services. **Do not enter data for those revenue centers not eligible for cost reimbursement or DRG payment, e.g. Home Health Agency, SNF, Hospice, Ambulance, residential treatment).**

**Line 100** - **If Observation Bed costs are reported on line 62 and included in line 25, enter one dollar (\$1.00).**

**Column 7**

**Lines 25-34, 37-97, and 100** - Multiply the charges in column 6 by the corresponding ratio in column 5. Enter the result rounded to the nearest dollar.

**Column 8**

**Lines 25-34 and 37-97** - Enter the total allowable outpatient charges from Worksheet C, part I, column 7 for each revenue center. **Do not include amounts for those revenue centers previously not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.**

NOV 29 2010

**Column 9**

**Lines 25-34 and 37-97** - Multiply the charges in column 8 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

**Column 10**

**Lines 25-34 and 37-97** - Enter charges for revenue centers that are not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.

**Column 11**

**Lines 25-34 and 37-97** - Multiply the charges in column 10 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

**Columns 1-11**

**Line 35** - Enter the total of lines 25 through 34.

**Line 98** - Enter the total of lines 37 through 97.

**Line 99** - Enter the total of lines 35 and 98.

**Line 101** - Enter the total of line 99 less line 100.

**(Line 101, Col. 4 must equal the sum of cols. 6, 8, & 10.)**

**Be sure to foot and cross-foot all columns.**

NOV 29 2010

## SCHEDULE C

## CALCULATION OF ROUTINE COSTS

**Column 1** - Transfer amounts from Schedule B, column 7, lines 25-33 to the appropriate lines. Enter the sum of lines 25-33 on line 35.

**Column 2** - Swing Beds - Transfer to line 25 the amount on Worksheet D-1, part I, line 26 as negative amounts. Enter the sum of lines 25-33 on line 35.

**Column 3** - For each line enter the sum of columns 1 and 2. Enter the sum of lines 25-33 on line 35.

**Column 4** - Enter the total days from Worksheet S-3, part I, column 6 to the appropriate lines. **If there are Observation Bed days reported on Worksheet S-3, line 26, column 6, or Employee Discount Days reported on Worksheet S-3, line 28, column 6. Include these days in Adult & Pediatric, line 25.** For Observation Bed days assigned directly to a subprovider, those days should be included with the subprovider's days rather than in Adults & Pediatric, line 25. Do not include swing bed days. **For free-standing psychiatric hospitals, do not include residential treatment days.** Enter the sum of lines 25-33 on line 35.

**Column 5** - Divide each line amount in column 3 by the corresponding days in column 4 for lines 25-33 and enter the result rounded to two decimal places.

**Column 6** - For each revenue center, enter the number of covered days of service rendered to Title XIX patients discharged during the reporting period. **Do not include Observation Bed days or non-covered days (e.g., swing bed, patients age 22-64 in free-standing psychiatric hospitals). Include transplant services that are paid on a DRG basis. (Do not include transplant services paid on a reasonable cost basis).** Enter the sum of lines 25-33 on line 35.

**Column 7** - For each revenue center, multiply the per diem calculated in column 5 by the XIX days reported in column 6 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

**Column 8** - For each revenue center, enter the number of covered days of service rendered to Title V patients discharged during the reporting period. **Do not include Observation Bed days or non-covered days.** Enter the sum of lines 25-33 on line 35.

**Column 9** - For each revenue center, multiply the per diem calculated in column 5 by the Title V days reported in column 8 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

**Column 10** - For each revenue center, enter the number of covered days of service rendered to Title XIX transplant patients discharged during the reporting period. **Include only transplant services paid on a reasonable cost basis. Do not include Observation Bed days, non-covered days, or transplant services paid by DRG.** Enter the sum of lines 25-33 on line 35.

**Column 11** - For each revenue center, multiply the per diem calculated in column 5 by the Title XIX transplant days reported in column 10 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

NOV 29 2010

## SCHEDULE C-1

## DISCHARGE STATISTICS

As defined in Ohio Administrative Code, rule 5101:3-2-02 (B)(17):

A patient is said to be "discharged" when he or she:

- (a) Is formally released from a hospital
- (b) Dies while hospitalized
- (c) Is discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part as described in paragraph(B)(8) of this rule or is discharged within the same hospital, from a bed in a psychiatric unit distinct part to an acute care bed;
- (d) Signs self out against medical advice (AMA).

The discharges reported on this schedule should also include the number of patients transferred to other facilities.

## SECTION I

**Column 1** - Enter, from Worksheet S-3, part I, column 15, the number of discharges for each revenue center. Enter the sum of lines 36-39 on line 40. **Although Total Facility Nursery Discharges are not detailed on Worksheet S-3, part I, please report Total Facility Nursery Discharges as maintained in your records.**

**Columns 2-4** - Enter the number of discharges from the facility for program patients. Title XIX services are classified by various rate years. Your fiscal year may not include every category. Only report discharges into the category that corresponds with your fiscal year. Enter the sum of each column on line 40.

- **Include in columns 2 and 3 any discharges for transplant services that are paid on a DRG basis. Any transplant services that are not reimbursed on a DRG basis should be reported in column 5.**
- **When reporting days in section I, lines 25a, 25b or 33, be sure to report corresponding discharges in section I, lines 37, 38 & 39.**

**Column 2-4, line 41** - Enter your capital add-on rate for the periods for which you reported discharges.

**Columns 7 & 8** - Enter the number of discharges from the facility for Medicaid HMO enrolled patients. Medicaid HMO services are classified by various rate years. Your fiscal year may not include every category. Only report discharges into the category that corresponds with your fiscal year. Enter the sum of each column on line 40.

- **When reporting days in Schedule C-2, section I, lines 25a, 25b or 33, be sure to report corresponding discharges in section I, lines 37, 38 & 39.**

## SECTION II

Outpatient visits should be counted as the number of final outpatient claims for which a hospital was paid and/or expects to receive payment. Series' accounts/cycle bills should be counted as 1 visit per claim (not the number of dates of service on that claim). Observation and emergency services claims should be counted as outpatient visits unless these visits turned into inpatient admissions on the same date of service.

**Line 42, column 1** - Enter the number of total facility outpatient visits.

**Line 42, column 2** - Enter the number of Medicaid outpatient visits on or before 12/31/07.

**Line 42, column 3** – Enter the number of Medicaid outpatient visits on or after 1/1/08.

**SECTION III**

**Line 43** - Enter as a sum, the number of beds on Worksheet S-3, part I, column 1, lines 12 and 14.

**Line 44** - Enter as a sum, the net number of interns and residents in an approved teaching program on Worksheet S-3, part I, column 9, lines 12, and 14.

## SCHEDULE C-2

### MEDICAID HMO INPATIENT DAYS

#### SECTION I

**Column 1** – Enter the per diem amounts from Schedule C, column 5, for each cost center in Lines 25 – 33.

**Column 2** – For each revenue center, enter the number of covered days of service rendered to Medicaid HMO patients discharged during the reporting period. Enter the sum of lines 25-33 on line 35.

**Column 3** – For each revenue center, multiply the per diem calculated in column 5 by the Medicaid HMO days reported in column 3 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

## SCHEDULE D

### TITLE XIX COST CALCULATIONS

**Include charges for the following;**

- Patients whose primary coverage was Ohio Medicaid Fee-for-Service and a payment was received directly from the Ohio Department of Job and Family Services.
- Patients whose Ohio Medicaid Fee-for-Service coverage was secondary to other insurance, (e.g. Blue Cross, Aetna, Railroad, etc.) and a payment was received from both the Primary Insurer and the Ohio Department of Job and Family Services.
- Patients whose Ohio Medicaid Fee-for-Service coverage was secondary to other insurance, (e.g. Blue Cross, Aetna, Railroad, etc.) and a payment was received from only the Primary Insurer and the claim was reported as "paid" on the Ohio Department of Job and Family Services remittance advice.
- Patients for any of the above situations for which you have submitted a claim and reasonably expect to receive a payment from the payer.

**Do Not Include charges for patients enrolled in Medicare or a Medicare Advantage Plan as Ohio Medicaid only pays cost sharing (coinsurance and/or deductible) for these claims.**

Hospitals are provided with Interim Paid Claims data indicating paid Medicaid Fee-for-Service claims through the date specified on the report. This information is provided as a courtesy to hospitals. Each hospital is expected to use its own accounting/patient information system to complete the cost report.

**Column 1** - Enter the ratio from Schedule B, column 5, for each revenue center on the corresponding line.

**Column 2**

**Lines 25-33 and 37-97** - Enter the charges for covered Title XIX inpatient services rendered during the reporting period. **Include transplant services that are reimbursed on a DRG basis.**

**Column 3**

**Lines 25-33** - Transfer the cost amounts from Schedule C, column 7, lines 25 to 33.

**Lines 37-97** - Multiply the charges in column 2 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Column 4**

**Lines 25-33** - **Enter charges for covered outpatient services only if outpatient charges are also reported on Schedule B.**

**Lines 37-97** - Enter the charges for covered outpatient services. **Do not include charges for Outpatient Laboratory Services, or any services which are not cost settled, (e.g., Pregnancy services).**

**Column 5**

**Lines 25-33 and 37-97** - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Column 6**

**Lines 41-44 and 70-97** - Enter the charges for Outpatient Laboratory Services.

**Column 7**

**Lines 41-44 and 70-97** - Multiply the charges in column 6 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Column 8**

**Lines 25-33 and 37-97** - Report only allowable charges for transplant services that are reimbursed on a reasonable cost basis during the reporting period.

**Column 9**

**Lines 25-33** - Transfer the cost amounts from Schedule C, column 11, lines 25-33.

**Lines 37-97** - Multiply the charges in column 8 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Columns 2-5 and 8-9**

**Line 35** - Enter the total of lines 25 through 33.

**Line 98** - Enter the total of lines 37 through 97.

**Line 101** - Enter the total of lines 35 and 98.

## SCHEDULE D-1

## TITLE V COST CALCULATIONS

**Column 1**

**Lines 25-33 and 37-97** - Transfer total cost amounts from Schedule B, column 3, to the corresponding lines.

**Column 2**

**Lines 25-33 and 37-97** - Enter the amount of cost associated with combined billing of provider based physician professional services as reported on Worksheet A-8-2, column 4.

**Column 3**

**Lines 25-33 and 37-97** - Enter the sum of columns 1 and 2.

**Column 4**

**Lines 25-33 and 37-97** - Transfer the total charge amounts from Schedule B, column 4, to the corresponding lines.

**Column 5**

**Lines 25-33 and 37-97** - Enter the amount of charges associated with the costs of combined billing of provider based physician professional services that are reported in column 2.

**Column 6**

**Lines 25-33 and 37-97** - Enter the sum of columns 4 and 5.

**Column 7**

**Lines 25-33 and 37-97** - Divide column 3 by column 6 and enter the resulting ratio, rounded to six decimal places, for each cost center.

**Column 8**

**Lines 25-33 and 37-97** - Enter the charges for covered inpatient Title V services rendered during the cost reporting period.

**Column 9**

**Lines 25-33** - Transfer the cost amounts from Schedule C, column 9.

**Lines 37-97** - Multiply the charges in column 8 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

**Column 10**

**Lines 25-33 and 37-97** - Enter the charges (including Outpatient Laboratory and Radiology services for covered outpatient Title V services) rendered during the reporting period.

**Column 11**

**Lines 25-33 and 37-97** - Multiply the charges in column 10 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

**Columns 1-11**

**Line 35** - Enter the total of lines 25 through 33.

**Line 98** - Enter the total of lines 37 through 97.

**Line 101** - Enter the total of lines 35 and 98.

## SCHEDULE E

### MEDICAL EDUCATION COSTS AND MISCELLANEOUS DATA

#### MEDICAL EDUCATION COSTS

**Line 1** – Enter the amount from Worksheet B, part I, column 20 – 20.XX, line 95.

**Line 2** – Enter the amount from Worksheet B, part I, column 21 – 21.XX, line 95.

**Line 3** – Enter the amount from Worksheet B, part I, columns 22 – 22.XX and 23 – 23.XX, line 95.

**Line 4** – Enter the amount from Worksheet B, part I, column 24 – 24.XX, line 95.

**Line 5** – Enter the total of lines 1 through 4.

#### XIX OUTPATIENT LAB PAYMENTS

**Line 6** - Enter the total Title XIX Outpatient Lab payments received that relate to charges reported on Schedule D, column 6, line 44.

#### NET PATIENT REVENUES | SECTION 1011 PAYMENTS

**Line 7a** – Enter the Net Patient Revenue amount from Worksheet G-3 line 3.

**Line 7b** – Enter the amount received for services provided under Section 1011 – Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. For additional information regarding Section 1011, please visit the following websites; [http://www.trailblazerhealth.com/Section\\_1011/Default.aspx?](http://www.trailblazerhealth.com/Section_1011/Default.aspx?) or [http://www.cms.hhs.gov/MLNProducts/downloads/Section\\_1011\\_Fact\\_Sheet.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf)

**SCHEDULE F**  
**HOSPITAL CARE ASSURANCE UNCOMPENSATED CARE**

*OUT-OF-STATE HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.*  
**OHIO ACUTE CARE HOSPITALS SHOULD COMPLETE SECTION I**  
**PSYCHIATRIC HOSPITALS SHOULD COMPLETE SECTION II**

**INDEPENDENT THIRD PARTY VALIDATION OF SCHEDULE F DATA**

Effective for Medicaid Cost Reports filed for cost reporting periods ending in State Fiscal Year (SFY) 2003, and each cost reporting period thereafter, each hospital, shall be required to have an independent party, external to the hospital, verify the data reported on Schedule F. The external reviewer shall at a minimum perform the data verification based on a set procedure as follows.

1. Verify that patient logs are maintained for the following categories of patients:
  - Disability Assistance inpatient charges, with insurance
  - Uncompensated care inpatient charges < 100% federal poverty income limits (FPL), with insurance
  - Disability Assistance outpatient charges, with insurance
  - Uncompensated care outpatient charges < 100% FPL, with insurance
  - Disability Assistance inpatient charges, with no insurance
  - Uncompensated care < 100% FPL, inpatient charges, with no insurance
  - Uncompensated care > 100% FPL, inpatient charges, with no insurance
  - Disability Assistance outpatient charges, with no insurance
  - Uncompensated care < 100% FPL, outpatient charges, with no insurance
  - Uncompensated care > 100% FPL, outpatient charges, with no insurance
  
2. Verify that the Hospital's patient logs include a date-of-service. Verify that the service dates for accounts with Disability Assistance coverage or family income < 100% FPL are recorded in the cost report period in which they occurred, and that the write-off dates for accounts with family incomes > 100% FPL, are recorded in the cost report period in which they were written-off. Verify that each log entry includes a unique (unduplicated) identifier for the patient, that is unique to the patient and not to each visit by the patient.
  
3. Verify that the supporting patient log totals for the data elements listed below agree to each data element on the Hospital's JFS 02930 Schedule F. If any of the elements do not match, return the patient logs to Hospital for correction.
  - Line 8, Columns 1 and 6 – Disability Assistance inpatient charges and receipts, with insurance
  - Line 9, Columns 1 and 6 – Uncompensated care < 100% FPL inpatient charges and receipts, with insurance
  - Line 12, Columns 1 and 6 – Disability Assistance, outpatient charges and receipts, with insurance
  - Line 13, Columns 1 and 6 – Uncompensated care < 100% FPL, outpatient charges and receipts, with insurance
  - Line 8, Columns 2 and 7 – Disability Assistance, inpatient charges and receipts, with no insurance
  - Line 9, Columns 2 and 7 – Uncompensated care < 100% FPL, inpatient charges and receipts, with no insurance
  - Line 10, Columns 2 and 7 – Uncompensated care > 100% FPL, inpatient charges and receipts, with no insurance
  - Line 12, Columns 2 and 7 – Disability Assistance outpatient charges and receipts, with no insurance
  - Line 13, Columns 2 and 7 – Uncompensated care < 100% FPL, outpatient charges and receipts, with no insurance
  - Line 14, Columns 2 and 7 – Uncompensated care > 100% FPL, outpatient charges and receipts, with no insurance

4. Verify the mathematical accuracy of Hospital's logs, by using at least the methodologies described below. If the logs were totaled manually, request adding machine tapes and match a sample of 10 entries on two of the tapes to the corresponding entries on the patient logs. If the logs were totaled with the use of an electronic spreadsheet, verify the accuracy of the formula(s) used. If the log entries were taken directly from the hospital's mainframe computer system, select one of the categories in Step 3 and tally the entries. If the logs do not foot, return the logs, and, if appropriate, the tapes to Hospital for correction.

5. From the hospital logs, select a random sample of entries from each of the ten data elements listed in Step 3, and verify the appropriateness of the write-off. The appropriateness of the write-off for each account selected shall be determined in accordance with Ohio Administrative Code (OAC) 5101:3-2-07.17 and the hospital's policies regarding the documentation of applicants' incomes.

The size of the required sample will vary according to which of three tiers the Hospital is placed in, using data from the current cost reporting period:

- If the hospital reports total uncompensated care charges for patients without insurance that is less than \$5.0 million, the size of the sample shall be at a minimum, 32 accounts: four in each of the six data categories identified in Step 3 for patients with no insurance and two in each of the categories for patients with insurance.
- If the hospital reports total uncompensated care charges for patients without insurance that is greater than \$5.0 million but less than \$10.0 million, the size of the sample shall be at a minimum, 64 accounts: eight in each of the six data categories identified in Step 3 for patients with no insurance and four in each of the categories for patients with insurance.
- If the hospital reports total uncompensated care charges for patients without insurance that is greater than \$10.0 million, the size of the sample shall be at a minimum, 96 accounts: 12 in each of the six data categories identified in Step 3 for patients with no insurance and six in each of the categories for patients with insurance.
- In addition to the above sample criteria, review all accounts for patients in the uncompensated care < 100% FPL, with no insurance categories which show receipts.

6. Obtain itemized statements from the Hospital for each of the patient accounts identified in the random selection of data elements identified in Step 5. Match the itemized statement to its corresponding entry in Hospital's log. Verify that patient accounts were correctly logged and entered in Schedule F, based on insurance status.

From the itemized statement, verify the patient's name, the date(s) of service, and whether the account is inpatient or outpatient and corresponds with the log entry. Subtract from the itemized statement any charges for services that can not be counted as "basic, hospital level" as described in OAC 5101:3-2-07.17 and OAC 5101:3-2-02, Appendix A. Verify that the sum of any subtraction of non-hospital level charges matches or does not exceed the entry for gross charges in Hospital's log. Verify that the total of all receipts on each selected account matches the receipts shown in the Hospital's log.

7. Obtain a copy of the Hospital's internal policy outlining its procedures for documenting applications for HCAP qualifying charity care or write-off.

8. Obtain copies of the documentation the Hospital used to determine eligibility for each of the patient accounts identified in the random selection of data elements identified in Step 5. Verify that the hospital's documentation practices are supported by its policy statement, obtained in Step 7, and are in accordance with OAC 5101:3-2-07.17.

9. From the eligibility documentation outlined in Step 8, verify that the patients were residents of Ohio, and not eligible for Medicaid according to OAC 5101:3-2-07.17. Verify that the patient accounts logged as eligible for Disability Assistance (DA) were in fact eligible for DA on the date(s) of service. For accounts of patients <100 % FPL, verify that Hospital used the appropriate Federal Poverty Income Guidelines that were in effect for the date(s) of service, and verify that the patient's income and family size on the date(s) of service were correctly calculated according OAC 5101:3-2-07.17.

10. Request a list of pending-Medicaid accounts from Hospital. Verify that no accounts that have been approved for Medicaid were included in any log or Schedule F entry.

11. The external reviewer shall issue a review report to the hospital.

#### Hospital Response to External Reviewer Report

The hospital must respond to the external reviewer with a written report which includes a course of corrective action taken by the hospital.

#### Re-verification of Schedule F Changes

Any hospital that submits an amended cost report that includes changes to data reported on Schedule F shall be required to have an independent CPA re-verify the data reported on Schedule F. The external reviewer shall, at a minimum, perform the data verification as follows:

1. When making wholesale changes, including reassigning amounts between write-off categories, the entire Schedule F data shall be reviewed as specified in step 5.
2. If only new accounts are added and no other changes to Schedule F are made, then the CPA shall select and review at least 5% of new accounts from each category in accordance with the review procedures steps 6 through 9. If the number of accounts to be reviewed under the 5% criteria exceeds the original sample size, then the entire Schedule F data shall be reviewed as specified in step 5.

#### External Data Validation Report

Each hospital shall retain all Schedule F data validation review reports for every cost report year, including recertification review reports and hospital responses to auditor reports, for a period of three years, and shall make such reports available to the department upon request, within three business days of such request.

### GENERAL INSTRUCTIONS (APPLIES TO ALL OF SECTION I):

Only discharges/visits and charges for hospital services may be included in Schedule F. Include only "Basic, medically necessary hospital level services" which are considered services in Appendix A of rule 5101:3-2-02 of the Ohio Administrative Code. Do not include charges related to physicians' services, transportation services, or take-home pharmacy items, and do not include visits to free standing clinics or surgery centers that are not hospital based. Do not include any portion of a patient account for a Medicaid recipient, regardless of whether the recipient is enrolled in an HMO or Medicaid fee-for-service. Do not include discharge/visits and charges that have been written off as Medicare bad debts.

Report uncompensated care information for patients with insurance in Column 1. Report uncompensated care information for patients without insurance in Column 2. Schedule F does not include a column for reporting total uncompensated care; it will be calculated by the department. Include any charges, inpatient discharges, and outpatient visits for patients eligible for "Hill-Burton" or covered by a local levy fund. Do not consider any Hill-Burton write-off or any payment by a local health care levy to be "insurance."

In both Column 6 and 7 the amount reported in lines 8 through 15 must equal all payments you have either received or reasonably expect to receive from these patients or their insurers. **For patients below poverty without insurance, rule 5101:3-2-07.17 of the Ohio Administrative Code requires that these patients receive care free of charge. There are very few circumstances which allow you to accept receipts for these accounts.**

**The data on uncompensated care for people on Disability Assistance in lines 8 and 12, and the data on uncompensated care for patients with family incomes below federal poverty guidelines in lines 9 and 13, may only include inpatient and outpatient accounts with discharge/visit dates that fall within your hospital's fiscal year. You must split-bill any outpatient accounts which cross these**

dates. Uncompensated care for patients with family incomes above federal poverty income guidelines may be included in lines 10 and 14 regardless of the service dates, so long as the date of the bad debt or charity care write-off fell within your hospital's fiscal year, and had not been previously written off.

## SECTION I (UNCOMPENSATED CARE FOR ACUTE CARE HOSPITALS)

### **Instructions for Column 1**

**COLUMN 1** Information in Column 1 should include data for patients who have received uncompensated care for some portion of their inpatient discharge or outpatient visit that was also covered by health insurance for the services provided.

#### **GROSS INPATIENT CHARGES**

**Line 8: Total DA Charges for Patients with Insurance - INPATIENT**

Enter the gross charges for inpatient discharges by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 9: Total UC Charges for Patients Below 100% with Insurance - INPATIENT**

Enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 10: Total UC Charges for Patients Above 100% with Insurance - INPATIENT**

Enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines, and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 11: Total Uncompensated Care Charges for Patients with Insurance - INPATIENT**

Enter the total of lines 8 through 10.

#### **GROSS OUTPATIENT CHARGES**

**Line 12: Total DA Charges for Patients with Insurance - OUTPATIENT**

Enter the gross charges for outpatient visits by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 13: Total UC Charges for Patients Below 100% with Insurance - OUTPATIENT**

Enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 14: Total UC Charges for Patients Above 100% with Insurance - OUTPATIENT**

Enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state can not be included of Schedule F.

**Line 15: Total Uncompensated Care Charges for Patients with Insurance - OUTPATIENT**

Enter the total of lines 12 through 14.

**INPATIENT DISCHARGES****Line 16: Total DA Inpatient Discharges for Patients with Insurance**

Enter the number of inpatient discharges for Disability Assistance patients who also had some form of insurance for the services delivered during your hospital's fiscal year.

**Line 17: Total UC Inpatient Discharges for Patients Below 100% with Insurance**

Enter the number of inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

**Line 18: Total UC Inpatient Discharges for Patients Above 100% with Insurance**

Enter the number of inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 19: Total UC Inpatient Discharges for Patients with Insurance**

Enter the total of lines 16 through 18.

**OUTPATIENT VISITS****Line 20: Total DA Outpatient Visits for Patients with Insurance**

Enter the number of outpatient visits for Disability Assistance patients who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 21: Total UC Outpatient Visits for Patients Below 100% with Insurance**

Enter the number of outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

**Line 22: Total UC Outpatient Visits for Patients Above 100% with Insurance**

Enter the number of outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 23: Total UC Outpatient Visits for Patients with Insurance**

Enter the total of lines 20 through 22.

**Instructions for Column 2**

**COLUMN 2** Information in Column 2 should include data for patients who have received uncompensated care and do not have any insurance for the services provided.

**GROSS INPATIENT CHARGES****Line 8: Total DA Charges for Patients without Insurance – INPATIENT**

Enter the gross charges for inpatient discharges by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year.

NOV 29 2010

**Line 9: Total UC Charges for Patients Below 100% without Insurance – INPATIENT**

Enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 10: Total UC Charges for Patients Above 100% without Insurance – INPATIENT**

Enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 11: Total Uncompensated Care Charges for Patients without Insurance – INPATIENT**

Enter the total of lines 8 through 10.

**GROSS OUTPATIENT CHARGES****Line 12: Total DA Charges for Patients without Insurance – OUTPATIENT**

Enter the gross charges for outpatient visits by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 13: Total UC Charges for Patients Below 100% without Insurance – OUTPATIENT**

Enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 14: Total UC Charges for Patients Above 100% without Insurance – OUTPATIENT**

Enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 15: Total Uncompensated Care Charges for Patients without Insurance – OUTPATIENT**

Enter the total of lines 12 through 14.

**INPATIENT DISCHARGES****Line 16: Total DA Inpatient Discharges for Patients without Insurance**

Enter the number of inpatient discharges for Disability Assistance patients who did not have insurance for the services delivered during your hospital's fiscal year.

**Line 17: Total UC Inpatient Discharges for Patients Below 100% without Insurance**

Enter the number of inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

**Line 18: Total UC Inpatient Discharges for Patients Above 100% without Insurance**

Enter the number of inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state cannot be included.

**Line 19: Total UC Inpatient Discharges for Patients without Insurance**

Enter the total of lines 16 through 18.

**OUTPATIENT VISITS****Line 20: Total DA Outpatient Visits for Patients without Insurance**

Enter the number of outpatient visits for Disability Assistance patients who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 21: Total UC Outpatient Visits for Patients Below 100% without Insurance**

Enter the number of outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

**Line 22: Total UC Outpatient Visits for Patients Above 100% without Insurance**

Enter the number of outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 23: Total UC Outpatient Visits for Patients without Insurance**

Enter the total of lines 20 through 22.

**Instructions for Column 3**

**COLUMN 3** Column 3 includes the Medicaid inpatient and outpatient cost to charge ratios for your hospital.

**Lines 8, 9, 10, and 11: Inpatient Cost to Charge Ratio**

Divide the sum of the values in column 3, line 101, of Schedule D and column 3, line 101, of Schedule I by the sum of the values in column 2, line 101, of Schedule D and column 2, line 101, of Schedule I to calculate the inpatient cost to charge ratio.

**Lines 12, 13, 14, and 15: Outpatient Cost to Charge Ratio**

Divide the sum of the values in column 5, line 101, of Schedule D and column 5, line 101, of Schedule I by the sum of the values in column 4, line 101, of Schedule D and column 4, line 101, of Schedule I to calculate the outpatient cost to charge ratio.

**Instructions for Columns 4 and 5****Calculation of Uncompensated Care Costs for Patients with Insurance****Lines 8 through 15: Column 4**

Multiply the value in column 1 by the value in column 3 for each line and subtract the value in column 6.

**Lines 8 through 15: Column 5**

Multiply the value in column 2 by the value in column 3 for each line and subtract the value in column 7.

**Instructions for Column 6**

**COLUMN 6** Information in Column 6 should include data for patients who have received uncompensated care for some portion of their inpatient discharge or outpatient visit that was also covered by health insurance for the services provided.

**INPATIENT RECEIPTS**

Receipts are to include ALL payments received or reasonably expect to receive on account, from patients or their insurers.

**Line 8: Total DA Receipts for Patients with Insurance – INPATIENT**

Enter the receipts for inpatient discharges by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 9: Total UC Receipts for Patients Below 100% with Insurance – INPATIENT**

Enter the receipts for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 10: Total UC Receipts for Patients Above 100% with Insurance – INPATIENT**

Enter the receipts for inpatient discharges for patients with family incomes above the federal poverty income guidelines, and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 11: Total Inpatient Uncompensated Care Receipts for Patients with Insurance – INPATIENT**

Enter the total of lines 8 through 10.

**OUTPATIENT RECEIPTS**

Receipts are to include ALL payments received or reasonably expect to receive on account, from patients or their insurers.

**Line 12: Total DA Receipts for Patients with Insurance – OUTPATIENT**

Enter the receipts for outpatient visits by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 13: Total UC Receipts for Patients Below 100% with Insurance – OUTPATIENT**

Enter the receipts for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 14: Total UC Receipts for Patients Above 100% with Insurance – OUTPATIENT**

Enter the receipts for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state can not be included of Schedule F.

**Line 15: Total Uncompensated Care Receipts for Patients with Insurance – OUTPATIENT**

Enter the total of lines 12 through 14.

**UNDUPLICATED INPATIENT DISCHARGES****Line 16: Total DA Unduplicated Inpatient Discharges for Patients with Insurance**

Enter the number of unduplicated inpatient discharges for Disability Assistance patients who also had some form of insurance for the services delivered during your hospital's fiscal year.

NOV 29 2010

**Line 17: Total UC Unduplicated Inpatient Discharges for Patients Below 100% with Insurance**

Enter the number of unduplicated inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

**Line 18: Total UC Unduplicated Inpatient Discharges for Patients Above 100% with Insurance**

Enter the number of unduplicated inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 19: Total UC Unduplicated Inpatient Discharges for Patients with Insurance**

Enter the total of lines 16 through 18.

**UNDUPLICATED OUTPATIENT VISITS****Line 20: Total DA Unduplicated Outpatient Visits for Patients with Insurance**

Enter the number of unduplicated outpatient visits for Disability Assistance patients who also had some form of insurance for the services delivered, during your hospital's fiscal year.

**Line 21: Total UC Unduplicated Outpatient Visits for Patients Below 100% with Insurance**

Enter the number of unduplicated outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

**Line 22: Total UC Unduplicated Outpatient Visits for Patients Above 100% with Insurance**

Enter the number of unduplicated outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 23: Total UC Unduplicated Outpatient Visits for Patients with Insurance**

Enter the total of lines 20 through 22.

**Instructions for Column 7**

**COLUMN 7** Information in Column 7 should include data for patients who have received uncompensated care and do not have any insurance for the services provided.

**INPATIENT RECEIPTS**

Receipts are to include ALL payments received or reasonably expect to receive on account, from patients or their insurers.

**Line 8: Total DA Receipts for Patients without Insurance – INPATIENT**

Enter the receipts for inpatient discharges by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 9: Total UC Receipts for Patients Below 100% without Insurance – INPATIENT**

Enter the receipts for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

NOV 29 2010

**Line 10: Total UC Receipts for Patients Above 100% without Insurance -- INPATIENT**

Enter the receipts for inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 11: Total Uncompensated Care Receipts for Patients without Insurance -- INPATIENT**

Enter the total of lines 8 through 10.

**OUTPATIENT RECEIPTS**

Receipts are to include ALL payments received or reasonably expect to receive on account, from patients or their insurers.

**Line 12: Total DA Receipts for Patients without Insurance -- OUTPATIENT**

Enter the receipts for outpatient visits by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 13: Total UC Receipts for Patients Below 100% without Insurance -- OUTPATIENT**

Enter the receipts for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 14: Total UC Receipts for Patients Above 100% without Insurance -- OUTPATIENT**

Enter the receipts for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 15: Total Uncompensated Care Receipts for Patients without Insurance -- OUTPATIENT**

Enter the total of lines 12 through 14.

**UNDUPLICATED INPATIENT DISCHARGES****Line 16: Total DA Unduplicated Inpatient Discharges for Patients without Insurance**

Enter the number of unduplicated inpatient discharges for Disability Assistance patients who did not have insurance for the services delivered during your hospital's fiscal year.

**Line 17: Total UC Unduplicated Inpatient Discharges for Patients Below 100% without Insurance**

Enter the number of unduplicated inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

**Line 18: Total UC Unduplicated Inpatient Discharges for Patients Above 100% without Insurance**

Enter the number of unduplicated inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state cannot be included.

**Line 19: Total UC Unduplicated Inpatient Discharges for Patients without Insurance**

Enter the total of lines 16 through 18.

NOV 29 2010

**UNDUPLICATED OUTPATIENT VISITS****Line 20: Total DA Unduplicated Outpatient Visits for Patients without Insurance**

Enter the number of unduplicated outpatient visits for Disability Assistance patients who did not have insurance for the services delivered, during your hospital's fiscal year.

**Line 21: Total UC Unduplicated Outpatient Visits for Patients Below 100% without Insurance**

Enter the number of unduplicated outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

**Line 22: Total UC Unduplicated Outpatient Visits for Patients Above 100% without Insurance**

Enter the number of unduplicated outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

**Line 23: Total UC Unduplicated Outpatient Visits for Patients without Insurance**

Enter the total of lines 20 through 22.

**SECTION II (FREE-STANDING PSYCHIATRIC HOSPITAL INFORMATION)**

**LINE 24** Only free-standing psychiatric hospitals should complete this section.

**Column 1: Payments from Insurance**

Enter payments received for psychiatric hospital inpatient services billed to and received from all sources other than the self-pay revenues in Column 2 and Ohio Medicaid payments reported on Schedule H.

**Column 2: Payments from Self-Pay**

Enter payments received for psychiatric hospital inpatient services billed to and received from either the person who received inpatient psychiatric services or the family of the person that received inpatient psychiatric service.

**Column 3: Charges for Charity Care**

Enter the total charges for psychiatric hospital services provided to indigent patients. This includes charges for services provided to individuals who do not possess health insurance for the services provided. However, this does not include bad debts, contractual allowances or uncompensated care costs rendered to patients with insurance where the full cost of service was not reimbursed because of per diem caps or coverage limitations.

**Column 4: Government Cash Subsidies Received**

Enter the amount of cash subsidies received directly from state and local governments for psychiatric hospital inpatient services.

**Column 5: Uncompensated Care Costs for Patients with Insurance**

Enter the psychiatric hospital inpatient costs for individuals that have insurance coverage for the service provided, but full reimbursement was not received due to per diem caps or coverage limitations.

**Column 6: Medicaid Days Provided to Medicaid Recipients Age 21 and Under**

Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 21 and under who were discharged during the hospital's fiscal year.

**Column 7: Medicaid Days Provided to Medicaid Recipients Age 22 to Age 64**

Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 22 to age 64 who were discharged during the hospital's fiscal year.

**Column 8: Medicaid Days Provided to Medicaid Recipients Age 65 and Over**

Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 65 and over who were discharged during the hospital's fiscal year.

NOV 29 2010

## SCHEDULE G

### TITLE XIX CAPITAL RELATED COST REIMBURSEMENT

*DRG EXEMPT HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.*

**Column 1**

**Lines 25-34 and 37-97** - For each revenue center, transfer the total charges from Schedule B, column 4, lines 25 through 34, and 37 through 97.

**Column 2**

**Lines 25-34 and 37-97** - For each revenue center, enter the "old" capital related cost from Worksheet B, Part II, column 25. The total of this column should match Worksheet B, Part II, column 25, line 95.

**Column 3**

**Lines 25-34 and 37-97** - For each revenue center, enter the "new" capital related cost from Worksheet B, Part III, column 25. The total of this column should match Worksheet B, Part III, column 25, line 95.

**Column 4**

**Lines 25-34 and 37-97** - Enter the sum of columns 2 and 3.

**Column 5**

**Lines 25-34 and 37-97** - Divide column 4 by column 1. Enter the result rounded to six decimal places.

**Column 6**

**Lines 25-34 and 37-97** - Enter the charge amounts from Schedule D, column 2.

**Column 7**

**Lines 25-34 and 37-97** - For each revenue center, multiply column 6 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

**Line 102** - Multiply the capital add-on rates in effect for the cost reporting period by the total number of XIX inpatient discharges on Schedule C-1, columns 2 and 3, line 40.

**Columns 1-7**

**Line 35** - Enter the total of lines 25 through 34.

**Line 98** - Enter the total of lines 37 through 97.

**Line 101** - Enter the total of lines 35 and 98.

**Column 7**

**Line 103** - Enter the result of line 102 less line 101.

## SCHEDULE H

## SETTLEMENT SUMMARY

**Section I. INPATIENT SERVICES**

**Line 1, columns 1-3** - Transfer amounts from Schedule D, column 3, line 101; Schedule D-1, column 9, line 101; and Schedule D, column 9, line 101, into the appropriate column.

**Line 2, columns 1-3** - Enter amounts paid by the program for services rendered to eligible program patients during the reporting period.

- ❖ **Do not include payments received under the Hospital Care Assurance or UPL programs.**
- ❖ **Include in column 1:**
  - **Payments for services received directly from the department when Ohio Medicaid is primary.**
  - **Payments for services received directly from the department when Ohio Medicaid is secondary to other insurance (Blue Cross, Aetna, Railroad, etc.)**
  - **DRG payments received for transplant services.**
- ❖ **Include in column 2 any payments received from the Ohio Department of Health for Title V services.**
- ❖ **Include in column 3, payments received from the department for transplant services which are paid on a reasonable cost basis.**
- ❖ **DO NOT INCLUDE amounts received from the department for Medicare crossover claims or from Ohio Medicaid Managed Care Plans.**

**Line 3, columns 1-3** - Enter the amount due from the program (based upon the reimbursement rate in effect when the service was rendered) for services rendered to eligible recipients during the reporting period for which reimbursement has not been received. See instructions for line 2 for the payments to include in each column.

**Line 4, columns 1-3** - Enter amounts received or receivable from other payers for services rendered to eligible program patients during the reporting period.

**Line 5, column 1** - Enter **GROSS Inpatient** UPL payments received for discharges occurring during this reporting period. Columns 2-4 reserved for JFS use.

**Line 6, column 1** - Enter amount due Program/(Provider), **using the opposite sign**, from Schedule G, column 7, line 103. *DRG-exempt and out-of-state hospitals, enter 0.*

**Line 7, columns 1-3** - Enter the sum of lines 2 through 6 (column 1 include line 5, column 4).

**Line 8, columns 1-3** - Transfer amounts from Schedule D, column 2, line 101; Schedule D-1, column 8, line 101; and Schedule D, column 8, line 101, into the appropriate column.

**In-State and DRG Exempt Hospitals move to Section II, line 10. DRG Out-of-State Hospitals complete line 9 before moving to Section II, line 10.**

**Line 9, column 1** - Enter the result of line 7 less line 8. If the result is negative, enter 0.

**CONTINUE TO SECTION II**

**Section II. OUTPATIENT SERVICES**

**Line 10, columns 1-2** - Transfer amounts from Schedule D, column 5, line 101 and Schedule D-1, column 11, line 101 into the appropriate columns.

**Line 11, columns 1-2** - Enter the amount paid by the program for services rendered to eligible program patients during the reporting period. See instructions for section I, line 2.

**Do Not Include** amounts paid by the programs for the following items:

1. Services billed under the At Risk Pregnancy program.
2. Amounts paid under the Hospital Care Assurance Program or UPL program.
3. Laboratory services with the exception of column 2 amounts which should include Title V payments for Outpatient Radiology and Laboratory services.

**Line 12, columns 1-2** - Enter the amount due from the program (based upon the reimbursement rate in effect when the service was rendered) for services rendered to eligible recipients during the reporting period for which reimbursement has not been received. See instructions for section I, line 2.

**Line 13, columns 1-2** - Enter amounts received or receivable from other payers for services rendered to eligible program patients during the reporting period.

**Line 14, columns 1** - Enter **GROSS Outpatient** UPL payments received for visits occurring during this reporting period. Column 2 – **LEAVE BLANK** – reserved for JFS use.

**Line 15, columns 1-2** - Enter the sum of lines 10 through 14 (column 1 include line 14, column 4).

**Line 16, columns 1-2** - Enter amounts from Schedule D, column 4, line 101 and Schedule D-1, column 10, line 101.

**In-State and DRG Exempt Hospitals move to Section III, line 20. DRG Out-of-State Hospitals complete lines 17 thru 19 before moving to Section IV, line 28.**

*Line 17, column 1* - Subtract line 15 from line 10.

*Line 18 column 1* - Subtract line 16 from line 10. If the result is negative enter -0-.

*Line 19, column 1* - Subtract line 17 from line 18.

**CONTINUE TO SECTION IV, LINE 28**

**Section III SETTLEMENT TEST**

**THIS SECTION IS ONLY TO BE COMPLETED BY ALL DRG Exempt, and In-State DRG Hospitals**

**Line 20, columns 1-3** - Combine amounts from each column of Schedule H, Section I, line 1, and Section II, line 10 into the appropriate column.

**Line 21, columns 1-3** - Combine amounts from each column of Schedule H, Section I, line 7, and Section II, line 15 into the appropriate column.

**Line 22, columns 1-3** - Combine amounts from each column of Schedule H, Section I, line 8, and Section II, line 16 into the appropriate column.

**Line 23, column 1** - Enter -0-. *DRG-exempt hospitals, subtract line 21 from line 20.*

**Line 23, columns 2 and 3** - Subtract line 21 from line 20.

NOV 29 2010

**Line 24, column 1** - Enter -0-. *DRG-exempt hospitals, subtract line 22 from line 20. If the result is negative, enter -0-.*

**Line 24, columns 2 and 3** - Subtract line 22 from line 20. If the result is negative, enter -0-.

**Line 25, column 1** - Enter the result of line 21 less line 22. If the result is negative, enter 0. *DRG-exempt hospitals, subtract line 23 from line 24.*

**Line 25, columns 2 and 3** - Subtract line 23 from line 24.

**Section IV PROGRAM(S) SUMMARY**

**Line 26, columns 1-3** - In-State DRG and DRG Exempt hospitals enter the amounts from Schedule H, Section III, line 25. Out-of-State DRG hospitals enter combined settlement amounts from Schedule H, Section I, line 9 and Schedule H, Section II, line 19.

**Line 27, column 1** - Enter the amount from Schedule G, column 7, line 103. *DRG-exempt hospitals, enter 0.*

**Line 29, columns 1-3** - Enter the sum of lines 26 and 27.

## SCHEDULE I

## TITLE XIX HMO COST CALCULATIONS

*OUT-OF-STATE HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.*

**Include charges for the following;**

- Patients whose primary coverage was an Ohio Medicaid Managed Care Plan and a payment was received directly from the Medicaid Managed Care Plan.
- Patients whose Ohio Medicaid Managed Care Plan coverage was secondary to other insurance, (e.g. Blue Cross, Aetna) and a payment was received from both the Primary Insurer and the Medicaid Managed Care Plan.
- Patients whose Ohio Medicaid Managed Care Plan coverage was secondary to other insurance, (e.g. Blue Cross, Aetna, Railroad, etc.) and a payment was received from only the Primary Insurer and the claim was reported as "paid" on the Ohio Medicaid Managed Care Plan remittance advice.
- Patients for any of the above situations for which you have submitted a claim and reasonably expect to receive a payment from the payer.

**Do Not Include charges for patients enrolled in Medicare or a Medicare Advantage Plan as Ohio Medicaid only pays cost sharing (coinsurance and/or deductible) for these claims.**

## SECTION I

**Column 1**

**Lines 25-33 and 37-97** - Enter the ratio from Schedule B, column 5 for each revenue center on the corresponding lines.

**Column 2**

**Lines 25-33 and 37-97** - Enter the charges for Title XIX covered inpatient services rendered during the reporting period.

**Column 3**

**Lines 25-33 and 37-97** - Multiply the charges in column 2 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Column 4**

**Lines 25-33, 37-40, and 45-97** - Enter the charges for Title XIX covered outpatient services. **Do not include charges for Outpatient Laboratory Services.**

**Column 5**

**Lines 25-33, 37-40, and 45-97** - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

**Column 6** - This column is reserved.

**Column 7**

**Lines 25-33 and 37-97** - Enter the ratio from Schedule G, column 5, for each revenue center on the corresponding line.

**Column 8**

**Lines 25-33 and 37-97** - Multiply the charges in column 2 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

**Line 102** - Multiply the capital add-on rates in effect for the cost reporting period by the total number of Medicaid HMO inpatient discharges on Schedule C-1, columns 7 and 8, line 40.

**Columns 2-8**

**Line 35** - Enter the total of lines 25 through 33.

**Line 98** - Enter the total of Lines 37 through 97.

**Line 101** - Enter the total of lines 35 and 98.

**SECTION II**

HMO Inpatient encounters should be counted as the number of HMO Inpatient discharges and the number of total inpatient days associated with the reported discharges, for which a hospital was paid and/or expects to receive payment.

HMO Outpatient encounters should be counted as the number of HMO Outpatient claims for which a hospital was paid and/or expects to receive payment. Series accounts/cycle bills should be counted as 1 visit per claim (not the number of dates of service on that claim).

**Line 103, column 2** - Enter the total XIX inpatient HMO days Schedule C-2, Column 2, Line 35.

**Line 103, column 4** - Enter the total XIX outpatient HMO visits.

**Line 104, column 2** - Enter the total facility inpatient HMO days.

**Line 104, column 4** - Enter the total facility outpatient HMO visits.

**Line 105, column 2** - Enter the total XIX inpatient HMO discharges Schedule C-1, column 7, line 40 plus Schedule C-1, column 8, line 40.

**Line 106, column 2** - Enter the total facility inpatient HMO discharges.

**Line 107** Report all amounts received or receivable as payment for the charges reported in Section I. Include all amounts received or receivable from Ohio Medicaid Managed Care Plans directly as well as those amount received or receivable from other payers (Blue Cross, Aetna, Railroad, etc) for Ohio Medicaid Managed Care enrollees.

**Line 107, column 2** - Enter the total XIX inpatient HMO payments,

**Line 107, column 4** - Enter the total XIX outpatient HMO payments.

Ohio Department of Job and Family Services  
**HOSPITAL COST REPORT**  
**STATE FISCAL YEAR 2010**  
CERTIFICATION BY OFFICER OF HOSPITAL

In accordance with current Medicaid regulations (42CFR, 455.18, 455.19) all cost reports must contain the following:

This is to certify that the foregoing information is true, accurate, and complete.  
I understand that payment of this Medicaid claim will be from Federal and State funds,  
and that any falsification, or concealment of a material fact, may be prosecuted under  
Federal and State laws.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report supporting schedules prepared for:

Provider Name	Medicaid Number	National Provider Identifier
Street Address	Federal ID Number	
City, State and Zip Code	Medicare Provider Number(s)	

for the cost reporting 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 provider(s) in accordance with applicable instructions and regulations including independent certification of Schedule F, and the accuracy of the OBRA Survey, except as noted.

Signature of Officer or Administrator of Provider(s)	Date of Signature
Print or Type Name	Title

Name of Individual Report Was Prepared By	Title
---	-------

Name of Person to Contact Regarding Report	Title
Telephone Number (Include Area Code & Extension (if applicable))	

**OBRA SURVEY**

Medicaid programs must, on an annual basis, determine whether hospitals which receive disproportionate share payments under Medicaid meet certain federally-mandated requirements. For instance, urban non-children's hospitals which receive disproportionate share payments and which offer non-emergency obstetrical services must have at least two obstetricians on staff who have agreed to service Medicaid patients. Rural hospitals which offer non-emergency obstetrical services must have at least two physicians (not necessarily obstetricians) who have agreed to provide obstetrical services to Medicaid recipients in order to receive Medicaid disproportionate share payments. A related requirement is that states must provide disproportionate share payments to hospitals with a low-income utilization rate that exceeds 25 percent.

Complete Section A and Section B for your facility for this cost reporting period.

**Section A**

- 1 Does your hospital predominantly serve patients less than 18 years of age? (If answer to this question is Yes, please proceed to Section B.)
- | Answer:               |                       |                       |
|-----------------------|-----------------------|-----------------------|
| YES                   | NO                    | N/A                   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
- 2 As of December 22, 1987, did your hospital offer non-emergency obstetric services to the general population? (If answer to this question is No, please proceed to Section B, if Yes answer question 3.)
- |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|-----------------------|
- 3 Does your hospital currently offer non-emergency obstetric services to the general population? (If answer to this question is Yes, please proceed to Section B.)
- |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|-----------------------|
- 4 Answer the one question below appropriate to your hospital. If your hospital is deemed a rural hospital for purposes of Medicare reimbursement, answer question (a). If your hospital is an urban hospital for purposes of Medicare reimbursement, answer question (b).
- a Rural: Does your hospital have at least two physicians (may or may not be obstetricians) with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? If you responded No, please explain below.
- |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|-----------------------|
- b Urban: Does your hospital have at least two obstetricians with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? If you responded No, please explain below.
- |                       |                       |                       |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|-----------------------|-----------------------|-----------------------|
- 

**Section B**

The following section should be completed by hospitals to determine if a low-income utilization rate (as described below) which exceeds 25% exists.

"Low-income utilization rate" means, according to federal law, the sum of (1) and (2) below:

- (1) the fraction, expressed as a percentage:
- (a) the numerator of which is the sum for a period of Medicaid (Ohio only) revenues (payments including HMO payments for patient services plus the amount of cash subsidies (including HCAP and UPL payments) for patient services received directly from state and local governments.
  - (b) the denominator of which is the total patient services revenue -- including such cash subsidies -- for the period.
- (2) the fraction, expressed as a percentage:
- (a) the numerator of which is the total (gross) hospital inpatient charges in a period attributable to charity care (not including contractual allowances and discounts and bad debts) less the portion of any subsidies received in the period from state and local governments reasonably attributed to inpatient hospital services.
  - (b) the denominator of which is total (gross) hospital inpatient charges in the period.

Provide the following information from your financial records:

Fraction 1	Medicaid Revenues:	<input style="width: 80%;" type="text"/>	
	Plus: Government Cash Subsidies:	<input style="width: 80%;" type="text"/>	Fraction (1)
	Total patient revenues including cash subsidies:	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>
Fraction 2	Total hospital inpatient charges for charity care (not including allowances, discounts and bad debts):	<input style="width: 80%;" type="text"/>	
	Less: Government cash subsidies:	<input style="width: 80%;" type="text"/>	Fraction (2)
	Total inpatient charges:	<input style="width: 80%;" type="text"/>	<input style="width: 80%;" type="text"/>
Sum of Fraction (1) and (2) expressed as a percent:			<input style="width: 80%;" type="text"/>

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES  
SFY 2010 INPATIENT  
BILLING CODE ALLOCATION

	UB-92 Revenue Center Codes
25. Adult & Pediatric	001, 100, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 230, 232, 239, 240-243, 249
25a. Distinct Part Psychiatric	114, 124, 134, 154
25b. Distinct Part Rehabilitation	118, 128, 138, 158
26. Intensive Care	200, 201-204, 208, 209, 233
27. Coronary Care	210-213, 219, 234
28. Burn Unit	207
29. Surgical Intensive Care	204
30. Other Special Care	*
31. Nursery Intensive Care	174
33. Nursery	170-173, 179, 231
37. Operating Room	360-362, 367, 369
37a. Ambulatory Surgery	490, 499
37b. Cast Room	700, 709
37c. Treatment or Observation Room	760-762, 769
38. Recovery Room	710, 719
39. Delivery & Labor Room	720-724, 729
40. Anesthesiology	370-372, 379
41. Radiology - Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
41a. CAT Scan	350-352, 359
41b. Ultrasound	402
41c. PET Scan	404
41d. MRI	610-612, 614-616, 618, 619
42. Radiology - Therapeutic	330-333, 335, 339
43. Radioisotope / Nuclear Medicine	340-342, 349
44. Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
44a. Oncology	280, 289
46. Whole Blood & Blood Components	380-387, 389
47. Blood Processing, Storing & Transfusion	390, 391, 399
48. Intravenous Therapy	260-264, 269
49. Respiratory Therapy	410, 412, 413, 419
49a. Pulmonary Function	460, 469
50. Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
50a. Cardiac Rehab	943
51. Occupational Therapy	430-434, 439
52. Speech & Hearing Services	440-444, 449
52a. Audiology	470-472, 479
53. Electrocardiology	480, 482, 483, 489, 730-732, 739
53a. Cardiac Catheterization	481
54. Electroencephalography	740, 749
55. Medical Supplies	270-272, 274-276, 278, 279, 291, 621-623
56. Pharmacy	250-252, 254, 255, 257-259, 634-637
57. Renal Dialysis	800-804, 809, 880-881, 889
58. Organ Acquisition	810-812, 819
59. Psychiatric/Psychological Services	900, 909, 910, 914-916, 918-919
60. Clinic	510-517, 519, 770, 771, 779
61. Emergency	450-452, 456, 459
62. Observation Beds	*
69. Gastrointestinal Services	750, 759
70. *	*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.

\*Billing codes should be allocated into revenue centers as indicated above. Any deviation from the above must be designated above to indicate where the billing codes were allocated, and why they were allocated differently than requested.

\*Do not include observation bed costs and charges reported on line 62 of the JFS 2930 and HCFA 2552-96 in revenue center 37b.

\*If one revenue center code is applicable to more than one revenue center, please show which revenue centers it was allocated to on the following page

\* Please list the revenue center codes allocated to these revenue centers.

NOV 29 2010

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES  
SFY 2010 OUTPATIENT  
BILLING CODE ALLOCATION

	UB-92 Revenue Center Codes
25. Adult & Pediatric	001, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169
25a. Distinct Part Psychiatric	114, 124, 134, 154
25b. Distinct Part Rehabilitation	118, 128, 138, 158
26. Intensive Care	
27. Coronary Care	
28. Burn Unit	
29. Surgical Intensive Care	
30. Other Special Care	
31. Nursery Intensive Care	
33. Nursery	170, 171, 179
37. Operating Room	360, 361, 369
37a. Ambulatory Surgery	490, 499
37b. Cast Room	700, 709
37c. Treatment or Observation Room	760-762, 769
38. Recovery Room	710, 719
39. Delivery & Labor Room	720-724, 729
40. Anesthesiology	370-372, 379
41. Radiology - Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
41a. CAT Scan	350-352, 359
41b. Ultrasound	402
41c. PET Scan	404
41d. MRI	610-612, 614-616, 618, 619
42. Radiology - Therapeutic	330-333, 335, 339
43. Radiolotope / Nuclear Medicine	340-342, 349
44. Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
44a. Oncology	280, 289
46. Whole Blood & Blood Components	380-387, 389
47. Blood Processing, Storing & Transfusion	390, 391, 399
48. Intravenous Therapy	260-264, 269
49. Respiratory Therapy	410, 412, 413, 419
49a. Pulmonary Function	460, 469
50. Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
50a. Cardiac Rehab	943
51. Occupational Therapy	430-434, 439
52. Speech & Hearing Services	440-444, 449
52a. Audiology	470-472, 479
53. Electrocardiology	480, 482, 483, 489, 730-732, 739
53a. Cardiac Catheterization	481
54. Electroencephalography	740, 749
55. Medical Supplies	270-272, 276, 278, 279, 621-623
56. Pharmacy	250-252, 254, 255, 258, 259, 634-637
57. Renal Dialysis	820, 821, 829-831, 839-841, 849-851, 859, 880, 881, 889
58. Organ Acquisition	
59. Psychiatric/Psychological Services	900, 909-911, 914-916, 918, 919, 944, 945
60. Clinic	510-517, 519, 770, 771, 779
61. Emergency	450-452, 456, 459
62. Observation Beds	*
69. Gastrointestinal Services	750, 759
70.	*
71.	*
72.	*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.  
Follow the same procedures as outlined on the Inpatient Billing Code Allocation Sheet

NOV 29 2010

Service Period	Provider Name			Stage
	NPI #	Provider #	Fed. ID.	Provider Type
JFS 02930 Settlement Summary				
SETTLEMENT SUMMARY	SPY 2010 Settlement Summary	Title XIX	Title XDX	Total
		Title V	Transplant	

1. AMT DUE ODJFS/(PROV)(2930-H)
2. AMT RECD WITH INT FILING
3. INTERIM SETTLEMENT AMOUNT
4. AMENDED INTERIM
5. AMENDED FINAL
6. NET AMT PD (SUM 2 THROUGH 5)
7. ADJUSTMENTS
8. TOTAL DUE ODJFS/(PROV)  
lines 1 - 6 +7

(\$)=Monies owed/paid to hospitals by ODJFS  
\$ = Monies owed/paid to ODJFS by hospitals

**\*\*N O T I C E \*\* THE ATTACHED WORKSHEETS MAY REFLECT MINOR DIFFERENCES CAUSED BY ROUNDING WHICH WILL NOT AFFECT THE SETTLEMENT RESULTS**

Settlement Approved By

Auditor In Charge  
Cost Reporting Unit

Date

NOV 25 2010

TN No. 10-006 Approval Date: \_\_\_\_\_  
SUPERSEDES  
TN No. 09-022 Effective Date: 07-01-2010

Service Period	Provider Name			Fed. ID.	Provider Type	Stage
	NPI #	Provider #				
						JFS 02930 Schedule A

1 INPATIENT    2 OUTPATIENT    3 TOTAL

1. Skilled Nursing Facility
2. Observation Beds
3. Home Health Agency
4. Home Dialysis
5. Meals on Wheels
6. Hospice
7. Professional Fees (SEE NOTE)
- 8.
- 9.
- 10.
- 11.
- 12.
- 13.
- 14.
- 15.
- 16.
- 17.
- 18.
- 19.
- 20.
- 21.
- 22.
- 23.
- 24.

NOTE: Please list professional fees by specific cost center.

NOV 29 2010

TN No. 10-006 Approval Date: \_\_\_\_\_  
SUPERSEDES  
TN No. 09-027 Effective Date: 07-01-2010

**Provider Name**  
 NPI # \_\_\_\_\_ Fed. ID. \_\_\_\_\_ Provider Type \_\_\_\_\_ State \_\_\_\_\_  
 JFS 02930 Schedule B

COST DISTRIBUTION	1		2		3		4		5		6		7		8		9		10		11	
	Facility Costs	Interns & Resident's Costs	Total Facility Costs	Total Facility Changes	Ratio (3/4)	Total J/P Charges	Total J/P Costs	Total O/P Charges	Total O/P Costs	Total O/P Non-Reim Charges	Total O/P Non-Reim Costs											
25. Adult & Ped																						
25a. Distinct Part Psych																						
25b. Distinct Part Phys Rehab																						
26. Intensive Care																						
27. Coronary Care																						
28. Burn Intensive Care																						
29. Surgical Intensive Care																						
30. Other Special Care																						
31. Nursery Intensive Care																						
33. Nursery																						
34. SNF / ICF																						
35. Sub-Total (Lines 25-34)																						
37. Operating Room																						
37a. Ambulatory Surgery																						
37b. Cast Room																						
37c. Treatment/Observ Room																						
38. Recovery Room																						
39. Delivery & Labor Room																						
40. Anesthesiology																						
41. Radiology-Diagnostic																						
41a. CAT Scan																						
41b. Ultrasound																						
41c. PET Scan																						
41d. MRI																						
42. Radiology-Therapeutic																						
43. Radioisotope/Nuclear Med																						
44. Laboratory																						
44A. Oncology																						
46. Whole BM & Packed Cells																						
47. Blood Store,Proc.& Trans																						
48. Intravenous Therapy																						
49. Respiratory Therapy																						
49a. Pulmonary Function																						
50. Physical Therapy																						
50a. Cardiac Rehabilitation																						
51. Occupational Therapy																						
52. Speech Therapy																						
52a. Audiology																						
53. Electrocardiology																						
53a. Cardiac Catheterization																						
54. Electroencephalography																						
55. Medical Supplies																						
56. Pharmacy																						
57. Renal Dialysis																						
58. Organ Acquisition																						
59. Psychiatric/Psychologic																						

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Service Period	Provider Name	Provider #	Fed. ID.	Stage

JFS 02930 Schedule B

	1	2	3	4	5	6	7	8	9	10	11
	Facility Costs	Interns & Residents Costs	Total Facility Costs	Total Facility Charges	Ratio (3/4)	Total I/P Charges	Total I/P Costs	Total O/P Charges	Total O/P Costs	Total O/P Non-Reim Charges	Total O/P Non-Reim Costs
60. Clinic											
61. Emergency											
62. Observation Beds											
63. Home Program Dialysis											
64. Ambulance											
65. Durable Med. Equip/Rentd											
66. Durable Med. Equip/Sold											
67. Home Health Agency											
68. Hospice											
69. Gastrointestinal Svcs											
70.											
71.											
72.											
73.											
74.											
75.											
76.											
77.											
78.											
79.											
80.											
98. Sub-Tot (Lns 37 To 97)											
99. Total (Lines 35 + 98)											
100. Less Observation Beds											
101. Total (Ln 99 - Ln 100)											

<b>Service Period</b> 10/1/9	<b>Provider Name</b>	<b>Provider #</b>	<b>Fac. ID.</b>	<b>Provider Type</b>	<b>Stage</b>
<b>TITLE XIX ROOM COST COMPUTATION</b>					

JFS 02930 Schedule C

	1 Total Costs All Patients	2 Swing Bed Costs	3 Adj Total Costs Col 1 + 2	4 Total Facility Days	5 Per Diem Col 3 / 4	6 Title XIX Days	7 Title XIX Costs Col 5 * 6	9 Title V Costs Col 5 * 8	10 Title XIX Trans Days	11 Title XIX Trans Costs Col 5 * 10
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**SECTION I**

- 25. Adult & Ped
- 25a. Distinct Part Psych
- 25b. Distinct Part Phys Rehab
- 26. Intensive Care
- 27. Coronary Care
- 28. Burn Intensive Care
- 29. Surgical Intensive Care
- 30. Other Special Care
- 31. Nursery Intensive Care
- 33. Nursery
- 35. Sub-Total (Lines 25-34)

**DISCHARGE STATISTICS**

**SECTION I - INPATIENT DATA**

- 36. Adult & Ped
- 37. Distinct Part Psych
- 38. Distinct Part Rehab
- 39. Nursery
- 40. Total
- 41. Capital Add-On Rate

**SECTION II - OUTPATIENT DATA**

- 42. Outpatient Visits

**SECTION III - MISC. DATA**

- 43. Total Hospital Beds
- 44. Net Number of Inbarns & Residents

**MEDICAID HMO INPATIENT DAYS**

**SECTION I**

- 25. Adult & Ped
- 25a. Distinct Part Psych
- 25b. Distinct Part Phys Rehab
- 26. Intensive Care
- 27. Coronary Care
- 28. Burn Intensive Care
- 29. Surgical Intensive Care
- 30. Other Special Care
- 31. Nursery Intensive Care
- 33. Nursery
- 35. Sub-Total (Lines 25-34)

JFS 02930 Schedule C-1

Medicaid HMO On  
or Before 12/31/09 or After 01/01/10

Title XIX  
Transplant

Title V

Title XIX On or  
After 01/01/10

Title XIX On or  
Before 12/31/09

Total Facility

Total Facility

JFS 02930 Schedule C-2

Medicaid HMO  
Costs

Medicaid HMO Days

Per Diem  
(Sec. 1, Col 5)

NOV 23 2010

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TN No. 09-027 Effective Date: 07-01-2010

Service Period	Provider Name	Provider #	Fed. ID.	Scope
TITLE XIX COST COMPUTATION				
				JFS 02930 Schedule D

1	2	3	4	5	6	7	8	9
Ratio	Title XIX I/P Charges	Title XIX I/P Costs	Title XIX O/P Charges	Title XIX O/P Costs	Title XIX O/P Lab Charges	Title XIX O/P Lab Costs	Title XIX Transplant Charges	Title XIX Transplant Costs
	25. Adult & Ped							
	25a. Distinct Part Psych							
	25b. Distinct Part Phys Rehab							
	26. Intensive Care							
	27. Coronary Care							
	28. Burn Intensive Care							
	29. Surgical Intensive Care							
	30. Other Special Care							
	31. Nursery Intensive Care							
	33. Nursery							
	35. Sub-Total (Lines 25-34)							
	37. Operating Room							
	37a. Ambulatory Surgery							
	37b. Cast Room							
	37c. Treatment/Observ Room							
	38. Recovery Room							
	39. Delivery & Labor Room							
	40. Anesthesiology							
	41. Radiology-Diagnostic							
	41a. CAT Scan							
	41b. Ultrasound							
	41c. PET Scan							
	41d. MRI							
	42. Radiology-Therapeutic							
	43. Radioisotope/Nuclear Med							
	44. Laboratory							
	44A. Oncology							
	46. Whole Bld & Packed Cells							
	47. Blood Store, Proc. & Trans							
	48. Intravenous Therapy							
	49. Respiratory Therapy							
	49a. Pulmonary Function							
	50. Physical Therapy							
	50a. Cardiac Rehabilitation							
	51. Occupational Therapy							
	52. Speech Therapy							
	52a. Audiology							
	53. Electrocardiology							
	53a. Cardiac Catheterization							
	54. Electroencephalography							
	55. Medical Supplies							
	56. Pharmacy							
	57. Renal Dialysis							
	58. Organ Acquisition							
	59. Psychiatric/Psychologic							
	60. Clinic							

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Service Period	Provider Name	Net #	Provider #	Fed. ID.	Provider Type	Stage
						JFS 02930 Schedule D

**TITLE XIX COST COMPUTATION**

1	2	3	4	5	6	7	8	9
Ratio	Title XIX I/P Charges	Title XIX I/P Costs	Title XIX O/P Charges	Title XIX O/P Costs	Title XIX O/P Lab Charges	Title XIX O/P Lab Costs	Title XIX Transplant Charges	Title XIX Transplant Costs

- 61. Emergency
- 62. Observation Beds
- 69. Gastrointestinal Svcs
- 70.
- 71.
- 72.
- 73.
- 74.
- 75.
- 76.
- 77.
- 78.
- 79.
- 80.
- 98. Sub-Total (Lns 37 To 97)
- 101. Total (Ln 38 + Ln 98)

Provider Name

Service Period	Provider #	Provider #	Fed. ID.	Provider Type	Stage
TITLE V COST COMPUTATION					

1 Total Costs 2 Prof. Component 3 Adjusted Costs 4 Total Charges 5 Prof. Component 6 Adjusted Charges 7 Ratio 8 Title V I/P Charges 9 Title V I/P Costs 10 Title V op Charges 11 Title V O/p Costs

JFS 02930 Schedule D1

- 25. Adult & Ped
- 25a. Distinct Part Psych
- 25b. Distinct Part Phys Rehab
- 26. Intensive Care
- 27. Coronary Care
- 28. Burn Intensive Care
- 29. Surgical Intensive Care
- 30. Other Special Care
- 31. Nursery Intensive Care
- 31. Nursery
- 35. Sub-Total (Lines 25-34)
- 37. Operating Room
- 37a. Ambulatory Surgery
- 37b. Cast Room
- 37c. Treatment/Obseav Room
- 38. Recovery Room
- 39. Delivery & Labor Room
- 40. Anesthesiology
- 41. Radiology-Diagnostic
- 41a. CAT Scan
- 41b. Ultrasound
- 41c. PET Scan
- 41d. MRI
- 42. Radiology-Therapeutic
- 43. Radioisotope/Nuclear Med
- 44. Laboratory
- 44a. Oncology
- 46. Whole Bld & Packed Cells
- 47. Blood Store, Proc. & Trans
- 48. Intravenous Therapy
- 49. Respiratory Therapy
- 49a. Pulmonary Function
- 50. Physical Therapy
- 50a. Cardiac Rehabilitation
- 51. Occupational Therapy
- 52. Speech Therapy
- 52a. Audiology
- 53. Electrocardiology
- 53a. Cardiac Catheterization
- 54. Electroencephalography
- 55. Medical Supplies
- 56. Pharmacy
- 57. Renal Dialysis
- 58. Organ Acquisition
- 59. Psychiatric/Psychologic
- 60. Clinic

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Service Period		Provider Name		Fed. ID.		Provider Type		Stage	
NPI #		NPI #		Fed. ID.		Provider Type		Stage	

JFS 02930 Schedule D1  
11  
Title V O/P Costs

	1	2	3	4	5	6	7	8	9	10	11
	Total Costs	Prof. Component	Adjusted Costs	Total Charges	Prof. Component	Adjusted Charges	Ratio	Title V I/P Changes	Title V I/P Costs	Title V op Changes	Title V O/P Costs
61. Emergency											
62. Observation Beds											
69. Gastrointestinal Svcs											
70.											
71.											
72.											
73.											
74.											
75.											
76.											
77.											
78.											
79.											
80.											
98. Sub-Tot (Lns 37 To 97)											
101. Total (Ln 38 + Ln 98)											

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Service Period	Provider Name	Provider #	Med. ID.	Provider Type	Scope
					JFS 02930 Schedule E/F

**Miscellaneous Cost & Payment Information**

Medical Education Add-on Verification  
 Direct:  
 Indirect:  
 (1 = Yes, 0 = No)

1. Non-Physician Anesthetists
2. Nursing School Costs
3. Interns & Residents Costs
4. Paramedic Education Costs
5. Total Med Ed Costs

Title XDX Lab Payments  
 6. Title XDX O/P Lab Payments

Net Patient Revenue | Section 1011 Payments  
 7a. Net Patient Revenue

**UNCOMPENSATED CARE DATA**

Section I	1 Gross Charges Patients w/ Insurance	2 Gross Charges Patients w/ No Insurance	3 Title XDX I/P & O/P Cost/Chg Ratio	4 Costs for Patients w/ Insurance	5 Costs for Patients w/ No Insurance	6 Receipts Patients w/ Insurance	7 Receipts Patients w/ No Insurance
Inpatient Charges							
8. Disability Assistance							
9. Uncompensated Care < 100%							
10. Uncompensated Care > 100%							
11. Total Inpatient							
Outpatient Charges							
12. Disability Assistance							
13. Uncompensated Care < 100%							
14. Uncompensated Care > 100%							
15. Total Outpatient							

Total Discharges / Visits Patients w/ Insurance

Total Discharges / Visits Patients w/ No Insurance

Section II	Payments From Insurance	Payments From Self-Pay	Charity From Charity Care	Gov't Cash Subsidies Rec.	Uncomp Costs Patients With Insurance	Medical Days Age 21 and Under	Medical Days Age 22 to 64	Medical Days Age 65 and Over
16. Disability Assistance								
17. Uncompensated Care < 100%								
18. Uncompensated Care > 100%								
19. Total Inpatient								
Outpatient Visits								
20. Disability Assistance								
21. Uncompensated Care < 100%								
22. Uncompensated Care > 100%								
23. Total Outpatient								

24. Required Data

Free Standing Psych Hospitals

NOV 29 2010

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TN No. 09-027 Effective Date: 07-01-2010

Service Period	Provider Name	Provider #	Fed. ID.	Provider Type	Stage
					JFS 02930 Schedule G

**CAPITAL RELATED COST REIMBURSEMENT**

	1	2	3	4	5	6	7
	Total Charges All Patients	Old Capital Cost	New Capital Cost	Total Capital Cost	Ratio	Title XDX I/P Charges	Title XDX Capital Cost
25. Adult & Ped							
25a. Distinct Part Psych							
25b. Distinct Part Phys Rehab							
26. Intensive Care							
27. Coronary Care							
28. Burn Intensive Care							
29. Surgical Intensive Care							
30. Other Special Care							
31. Nursery Intensive Care							
33. Nursery							
34. SNF / ICF							
35. Sub-Total (Lines 25-34)							
37. Operating Room							
37a. Ambulatory Surgery							
37b. Cast Room							
37c. Treatment/Observ Room							
38. Recovery Room							
39. Delivery & Labor Room							
40. Anesthesiology							
41. Radiology-Diagnostic							
41a. CAT Scan							
41b. Ultrasound							
41c. PET Scan							
41d. MRI							
42. Radiology-Therapeutic							
43. Radioisotope/Nuclear Med							
44. Laboratory							
44a. Oncology							
46. Whole Bld & Packed Cells							
47. Blood Store, Proc. & Trans							
48. Intravenous Therapy							
49. Respiratory Therapy							
49a. Pulmonary Function							
50. Physical Therapy							
50a. Cardiac Rehabilitation							
51. Occupational Therapy							
52. Speech Therapy							
52a. Audiology							
53. Electrophysiology							
53a. Cardiac Catheterization							
54. Electroencephalography							
55. Medical Supplies							
56. Pharmacy							
57. Renal Dialysis							
58. Organ Acquisition							
59. Psychiatric/Psychologic							

NOV 19 2010

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Service Period	Provider Name	Provider #	Fed. ID.	Provider Type	State
					JFS 02930 Schedule G

**CAPITAL RELATED COST REIMBURSEMENT**

1 Total Charges All Patients  
2 Old Capital Cost  
3 New Capital Cost  
4 Total Capital Cost  
5 Ratio  
6 Title XX I/P Changes  
7 Title XX Capital Cost

- 60. Clinic
- 61. Emergency
- 62. Observation Beds
- 63. Home Program Dialysis
- 64. Ambulance
- 65. Durable Med. Equip/Rentd
- 66. Durable Med. Equip/Sold
- 67. Home Health Agency
- 68. Hospice
- 69. Gastrointestinal Svcs
- 70.
- 71.
- 72.
- 73.
- 74.
- 75.
- 76.
- 77.
- 78.
- 79.
- 80.
- 98. Sub-Tot (Lns 37 To 97)
- 101. Total
- 102. Capital Payments For Period
- 103. Amount Due Program/(Provider)

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<b>Service Period</b>	<b>Provider Name</b>	<b>Provider #</b>	<b>Fed. ID.</b>	<b>Provider Type</b>	<b>Stage</b>
					JFS 02930 Schedule H

**SETTLEMENT CALCULATION**

	1	2	3	4
Title XDX	Title XDX	Transplant	Title XDX Misc.	Adjustments
<b>Section I I/P Services</b>				
1. Inpatient Program Cost				
2. Amount Received From Program				
3. Amount Receivable From Program				
4. Amount Recv'd/Due 3rd Party Payors				
5. Upper Limit Payments   Misc Adjustments				
6. Capital Pymts (2930-G)				
7. Total I/P Payments				
8. Total Program Charges				
9. Out Of State Pymnt Over Chgs/Cost				
<b>Section II O/P Services</b>				
10. Outpatient Program Cost				
11. Amount Received From Program				
12. Amount Receivable From Program				
13. Amount Recv'd/Due 3rd Party Payors				
14. Upper Limit Payments   Misc. Adjustments				
15. Total O/P Payments				
16. Total Program Charges				
17. Costs Over Payments				
18. Costs Over Charges				
19. Out Of State Pymnt Over Chgs/Cost				
<b>Section III Upper Payments Test</b>				
20. I/P & O/P Program Costs				
21. I/P & O/P Program Payments				
22. I/P & O/P Program Charges				
23. Payments Over Costs				
24. Charges Over Costs				FALSE
25. Payments Over Costs/Charges				FALSE
<b>Section IV Program Summary</b>				
26. Settlement (Section III, Line 27)				
27. Cap Cost Due Program/(Provider)				
28. Total Amount Due Program/(Provider)				

NOV 20 2010

Service Period	Provider Name		Provider #	Fed. ID.	Provider Type	State
						JFS 02930 Schedule I

Title XDX HMO Cost Computation

	1	2	3	4	5	6	7	8
	Ratio	Title XDX HMO I/P Charges	Title XDX HMO I/P Costs	Title XDX HMO O/P Charges	Title XDX HMO O/P Costs		Capital Ratio	Title XDX HMO Capital Costs
25. Adult & Ped								
25a. Distinct Part Psych								
25b. Distinct Part Phys Rehab								
26. Intensive Care								
27. Coronary Care								
28. Burn Intensive Care								
29. Surgical Intensive Care								
30. Other Special Care								
31. Nursery Intensive Care								
33. Nursery								
35. Sub-Total (Lines 25-34)								
37. Operating Room								
37a. Ambulatory Surgery								
37b. Cast Room								
37c. Treatment/Observ Room								
38. Recovery Room								
39. Delivery & Labor Room								
40. Anesthesiology								
41. Radiology-Diagnostic								
41a. CAT Scan								
41b. Ultrasound								
41c. PET Scan								
41d. MRI								
42. Radiology-Therapeutic								
43. Radioisotope/Nuclear Med								
44. Laboratory								
44A. Oncology								
46. Whole BM & Packed Cells								
47. Blood Store,Proc.& Trans								
48. Intravenous Therapy								
49. Respiratory Therapy								
49a. Pulmonary Function								
50. Physical Therapy								
50a. Cardiac Rehabilitation								
51. Occupational Therapy								
52. Speech Therapy								
52a. Audiology								
53. Electrocardiology								
53a. Cardiac Catheterization								
54. Electroencephalography								
55. Medical Supplies								
56. Pharmacy								
57. Renal Dialysis								
58. Organ Acquisition								
59. Psychiatric/Psychologic								
60. Clinic								

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Service Period	Provider Name	Provider #	Fac. ID.	Provider Type	Stage
					JFS 02930 Schedule I

Title XDX HMO Cost Computation

	1	2	3	4	5	6	7	8
	Ratio	Title XDX HMO I/P Charges	Title XDX HMO I/P Costs	Title XDX HMO O/P Charges	Title XDX HMO O/P Costs		Capital Ratio	Title XDX HMO Capital Costs
61. Emergency								
62. Observation Beds								
69. Gastrointestinal Svcs								
70.								
71.								
72.								
73.								
74.								
75.								
76.								
77.								
78.								
79.								
80.								
98. Sub-Tot (Lns 37 To 97)								
101. Total (Ln 38 + Ln 98)								
102. Estimate of Capital Payments								
103. Title XDX HMO Days/Visits								
104. Total Facility HMO Days/Visits								
105. Title XDX HMO Discharges								
106. Total Facility HMO Discharges								
107. Title XDX HMO Payments								

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