

5101:3-3-01 **Definitions.**

Except as otherwise provided in Chapter 5101:3-3 of the Administrative Code:

(A) "Allowable costs" are those costs incurred for certified beds in a facility as determined by the Ohio department of job and family services (ODJFS) to be reasonable, as set forth under paragraph (AA) of this rule, and do not include fines paid under sections 5111.35 to 5111.62, 5111.683, and 5111.99 of the Revised Code. Unless otherwise enumerated in Chapter 5101:3-3 of the Administrative Code, allowable costs are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

- (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (10/1/2005);
- (2) The provider reimbursement manual (CMS Publication 15-1, [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals)); or
- (3) Generally accepted accounting principles in accordance with standards prescribed by the "American Institute of Certified Public Accountants" (AICPA) as in effect on the effective date of this rule. These standards can be obtained at [www.aicpa.org](http://www.aicpa.org).

(B) "Ancillary and support costs" means costs for NFs other than the costs listed under the direct care, tax, or capital components in the NF chart of accounts. Ancillary and support costs include, but are not limited to, the following: dietary payroll taxes, fringe benefits, staff development; medical/habilitation, pharmaceutical and incontinence supplies; activity and habilitation/rehabilitation; medical minor equipment; utility expenses; administrative and general services; home office costs; maintenance and minor equipment; equipment acquired by operating lease; ancillary/support payroll taxes, fringe benefits, and staff development; and non-reimbursable expenses.

(C) "Annual facility average case-mix score" is the score used to calculate the facility's cost per case-mix unit.

(D) "Capital costs" means costs of ownership and nonextensive renovation.

(1) "Cost of ownership" means the actual expense incurred for all of the following:

(a) Depreciation and interest on any items capitalized including the following:

- (i) Buildings;
- (ii) Building improvements;

- (iii) Equipment;
  - (iv) Extensive renovation;
  - (v) Transportation equipment;
  - (vi) Replacement beds;
- (b) Amortization and interest on land improvements and leasehold improvements;
- (c) Amortization of financing costs;
- (d) Except as provided under paragraph (M) of this rule, lease and rent of land, building, and equipment.
- (2) "Costs of nonextensive renovation" means the actual expense incurred for depreciation or amortization and interest on renovations that are not extensive renovations.
- (E) "Capital lease" and "operating lease" shall be construed in accordance with generally accepted accounting principles.
- (F) "Case mix score" means the measure of the relative direct-care resources needed to provide care and rehabilitation to a resident of a nursing facility (NFs) or intermediate care facility for the mentally retarded (ICFs-MR).
- (G) "Cost of construction" means the costs incurred for the construction of beds originally contained in the NF or ICF-MR and the costs incurred for the construction of beds added to the NF or ICF-MR after the construction of the original beds. In the case of NFs or ICFs-MR which extensively renovate, "cost of construction" includes the costs incurred for the extensive renovation.
- (H) "Cost per case mix unit" Cost per case mix unit for ICFs-MR is determined annually. The "cost per case mix unit" is calculated by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for the applicable calendar year preceding the fiscal year in which the rate will be paid by the facility's annual average case mix score for the applicable calendar year.
- (I) "Date of licensure," for a facility originally licensed as a nursing home under Chapter 3721. of the Revised Code, means the date specific beds were originally licensed as nursing home beds under that chapter, regardless of whether they were subsequently licensed as residential facility beds. For a facility originally licensed as a residential facility, "date of licensure" means the date specific beds were originally licensed as residential facility beds under that section.

- (1) If nursing home beds licensed under Chapter 3721. of the Revised Code or residential facility beds licensed under section 5123.19 of the Revised Code were not required by law to be licensed when they were originally used to provide nursing home or residential facility services, "date of licensure" means the date the beds first were used to provide nursing home or residential facility services, regardless of the date the present provider obtained licensure.
- (2) If a facility adds nursing home or residential facility beds or in the case of an ICF-MR with more than eight beds or a NF, it extensively renovates the facility after its original date of licensure, it will have a different date of licensure for the additional beds or for the extensively renovated facility, unless, in the case of the addition of beds, the beds are added in a space that was constructed at the same time as the previously licensed beds but was not licensed under Chapter 3721. or section 5123.19 of the Revised Code at that time. The licensure date for additional beds or facilities which extensively renovate shall be the date the beds are placed into service.
- (J) "Desk reviewed" means that costs as reported on a cost report have been subjected to a desk review and preliminarily determined to be allowable costs.
- (K) "Direct care costs" means costs as defined under rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code.
- (L) "Fiscal year" means the fiscal year of this state, as specified in section 9.34 of the Revised Code.
- (M) "Indirect care costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.
- (N) "Inpatient days" means all days during which a resident, regardless of payment source, occupies a bed in a NF or ICF-MR that is included in the facility's certified capacity under Title XIX of the "Social Security Act," 49 stat. 620 (1935), 42 U.S.C.A. 301, as amended. Therapeutic or hospital leave days for which payment is made under section 5111.33 of the Revised Code are considered inpatient days proportionate to the percentage of the facility's per resident per day rate paid for those days.
- (O) "Intermediate care facility for the mentally retarded" (ICF-MR) means an intermediate care facility for the mentally retarded certified as in compliance with applicable standards for the medical assistance program by the director of health in accordance with Title XIX of the "Social Security Act."
- (P) "Maintenance and repair expenses" means expenditures, except as provided in paragraph (EE) of this rule, that are necessary and proper to maintain an asset in a

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normally efficient working condition and that do not extend the useful life of the asset two years or more. Maintenance and repairs expense may include, but are not limited to, the cost of ordinary repairs such as painting and wallpapering.

- (Q) "Minimum data set" (MDS) is the resident assessment instrument approved by the centers for medicare and medicaid services (CMS). The MDS provides the resident assessment data which is used to classify the resident into a resource utilization group in the RUG case-mix classification system, is the foundation for planning and delivering care to nursing facility residents, and is used in the calculation of nursing facility reimbursement rates.
- (R) "Nursing facility" (NF) means a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is not an intermediate care facility for the mentally retarded (ICF-MR). "Nursing facility" includes a facility, or a distinct part of a facility, that is certified as a nursing facility by the director of health in accordance with Title XIX of the "Social Security Act," and is certified as a skilled nursing facility by the director in accordance with Title XIX of the "Social Security Act."
- (S) "Other protected costs" means costs as defined under rule 5101:3-3-71 of the Administrative Code.
- (T) "Outlier" means residents who have special care needs as defined under rule 5101:3-3-17 of the Administrative Code.
- (U) "Owner" means any person or government entity that has at least five per cent ownership or interest, either directly, indirectly, or in any combination, in a NF or ICF-MR.
- (V) "Patient" includes resident or individual.
- (W) "Provider" means a person or government entity that operates a NF or ICF-MR under a provider agreement.
- (X) "Provider agreement" means a contract between ODJFS and an operator of a NF or ICF-MR for the provision of NF or ICF-MR services under the medical assistance program. The signature of the operator or the operator's authorized agent binds the operator to the terms of the agreement.
- (Y) "Purchased nursing services" means services that are provided by registered nurses, licensed practical nurses, or nurse aides who are temporary personnel furnished by a nursing pool on behalf of the facility. These personnel are not considered to be employees of the facility.

- (Z) "Quarterly facility average case-mix score" is the facility average case-mix score based on data submitted for one reporting quarter.
- (AA) "Reasonable" means that a cost is an actual cost that is appropriate and helpful to develop and maintain the operation of patient care facilities and activities, including normal standby costs, and that does not exceed what a prudent buyer pays for a given item or services. Reasonable costs may vary from provider to provider and from time to time for the same provider.
- (BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:
- (1) An individual who is a relative of an owner is a related party.
  - (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
  - (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.
  - (4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:
    - (a) A supplier is a separate bona fide organization;
    - (b) A substantial part of the supplier's business activity of the type carried on with the provider is transacted with others than the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;
    - (c) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;
    - (d) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

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- (5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "A" which owns fifty per cent of corporation "B" results in a twenty per cent indirect interest in corporation "B").
- (6) If a provider transfers an interest or leases an interest in a facility to another provider who is a related party, the capital cost basis shall be adjusted for a sale of a facility to or a lease to a provider that is not a related party if all of the following conditions are met:
- (a) For a NF transfer:
- (i) The related party is a relative of owner.
- (ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.
- (iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:
- (a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:
- (i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year, plus four per cent; or
- (ii) Fifteen per cent.
- (b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.
- (c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the

actual change of provider agreement(s) for each facility transferred to a related party.

- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(b) For a NF lease:

- (i) The related party is a relative of owner.
- (ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.
- (iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:
  - (a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.
  - (b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.
  - (c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.
- (iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the

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same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.

(c) For an ICF-MR transfer:

(i) The related party is a relative of owner.

(ii) The provider making the transfer retains no interest in the facility except through the exercise of the creditor's rights in the event of default.

(iii) ODJFS determines that the transfer is an arm's length transaction if all the following apply:

(a) Once the transfer goes into effect, the provider that made the transfer has no direct or indirect interest in the provider that acquires the facility or the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a creditor. If the provider making the transfer maintains an interest as a creditor, the interest rate of the creditor shall not exceed the lesser of:

(i) The prime rate, as published by the "Wall Street Journal" on the first business day of the calendar year plus four per cent; or

(ii) Fifteen per cent.

(b) The provider that made the transfer does not reacquire an interest in the facility except through the exercise of a creditor's rights in the event of a default. If the provider reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the transfer never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) The provider transferring their facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility transferred to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a provider making the transfer who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

(d) For an ICF-MR lease:

(i) The related party is a relative of owner.

(ii) The lessor retains an ownership interest in only real property and any improvements on the real property except when a lessor retains ownership interest through the exercise of a lessor's rights in the event of default.

(iii) ODJFS determines that the lease is an arm's length transaction if all the following apply:

(a) Once the lease goes into effect, the lessor has no direct or indirect interest in the lessee or, except as provided in this rule, the facility itself, including interest as an owner, officer, director, employee, independent contractor, or consultant, but excluding interest as a lessor.

(b) The lessor does not reacquire an interest in the facility except through the exercise of a lessor's rights in the event of a default. If the lessor reacquires an interest in the facility in this manner, ODJFS shall treat the facility as if the lease never occurred when ODJFS calculates its reimbursement rates for capital costs.

(c) A lessor that proposes to lease a facility to a relative of owner shall obtain a certified appraisal(s) for each facility leased. The lessor of the facility shall provide ODJFS with certified appraisal(s) at least ninety days prior to the actual change of provider agreement(s). The certified appraisal(s) shall be conducted no earlier than one hundred eighty days prior to the actual change of provider agreement(s) for each facility leased to a related party.

(iv) Except in the case of hardship caused by a catastrophic event, as determined by ODJFS, or in the case of a lessor who is at least sixty-five years of age, not less than twenty years have elapsed since, for the same facility, the capital cost basis was determined or adjusted most recently; or actual, allowable cost of ownership was determined most recently.

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- (v) The provisions set forth in this paragraph do not apply to leases of specific items of equipment.
- (e) The provider shall notify ODJFS in writing and shall supply sufficient documentation demonstrating compliance with the provisions of this rule no less than ninety days before the anticipated date of completion of the transfer or lease. In the case of a transaction completed before December 28, 2000 and subject to CMS approval the provider shall supply sufficient documentation demonstrating compliance with the provisions of this rule within thirty days of the effective date of this rule. If the provider does not supply any of the required information, the provider shall not qualify for a rate adjustment. ODJFS shall issue a written decision determining whether the transfer meets the requirements of this rule within sixty days after receiving complete information as determined by ODJFS.
- (f) Subject to approval by CMS of a state plan amendment authorizing such, the provisions of paragraph (BB)(6) of this rule shall apply to any transfer or lease that meets the requirements specified in paragraph (BB)(6) of this rule that occurred prior to December 28, 2000. Any rate adjustments which result from the provisions contained in paragraph (BB)(6) of this rule shall take effect as specified in rule 5101:3-3-24 of the Administrative Code, following a determination by ODJFS that the requirements of paragraph (BB)(6) of this rule are met. A provider seeking a determination from ODJFS that a transaction occurring prior to December 28, 2000, meets the requirements of this rule shall submit the necessary documentation under paragraph (BB)(6)(e) of this rule no later than thirty days after the effective date of this rule.
- (CC) "Relative of owner" means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:
- (1) Spouse;
  - (2) Natural parent, child, or sibling;
  - (3) Adopted parent, child, or sibling;
  - (4) Stepparent, stepchild, stepbrother, or stepsister;
  - (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
  - (6) Grandparent or grandchild;

(7) Foster parent, foster child, foster brother, or foster sister.

(DD) "Extensive renovation" means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years. To calculate the per-bed cost of a renovation project for purposes of determining whether it is an extensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. Allowable extensive renovations are considered an integral part of cost of ownership as set forth under paragraph (D) of this rule.

(1) For purposes of paragraph (DD) of this rule, the cost of constructing a new bed shall be considered to be forty thousand dollars, adjusted for inflation from January 1, 1993 to the end of the calendar year during which the renovation is completed using the consumer price index for shelter costs for all urban consumers for the north central region, as published by the United States bureau of labor statistics.

(2) ODJFS may treat a renovation that costs more than eighty-five per cent of the cost of constructing new beds as an extensive renovation if ODJFS determines that the renovation is more prudent than construction of new beds.

(EE) "Nonextensive renovation" means the betterment, improvement, or restoration of an ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. To calculate the per-bed cost of a renovation project for purposes of determining whether it is a nonextensive renovation, the allowable cost of the project shall be divided by the number of beds in the facility certified for participation in the medical assistance program, even if the project does not affect all medicaid-certified beds. A nonextensive renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A nonextensive renovation may include costs that otherwise would be considered maintenance and repair expenses if they are included as part of the nonextensive renovation project and are an integral part of the structural change that makes up the nonextensive renovation project. Nonextensive renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity. Allowable nonextensive renovations are not considered cost of ownership as set forth under paragraph (D) of this rule.

(FF) The definitions established in paragraphs (DD) and (EE) of this rule apply to "extensive renovations" and "nonextensive renovations" approved by ODJFS on or after July 1, 1993. Any betterments, improvements, or restorations of NFs or ICFs-MR for which construction is started before July 1, 1993, and that meet the definitions of extensive renovations or nonextensive renovations established by the

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rules of ODJFS in effect on December 22, 1992, shall be considered extensive renovations or nonextensive renovations. For purposes of renovations approved by ODJFS, "construction is started" means the date in which the actual construction work begins at the facility site.

(GG) "Replacement beds" are beds which are relocated to a new building or portion of a building attached to and/or constructed outside of the original licensed structure of a NF or ICF-MR. Replacement beds may originate from within the licensed structure of a NF or ICF-MR from another NF or ICF-MR. Replacement beds are eligible for the cost of ownership efficiency incentive ceiling which corresponds to the period the beds were replaced.

(HH) "RUGs" is the resource utilization groups system of classifying NF residents into case-mix groups.

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Attachment 4.19D  
Supplement 2  
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"SUNSHINE/KING ROAD FAMILY CARE HOME is an ICF-MR outlier provider on the Medicaid program. SUNSHINE/KING ROAD FAMILY CARE HOME receives a per diem rate of ~~\$455.34~~ \$481.96 per resident per day for each Medicaid resident in lieu of the calculated rate set forth under ICF-MR Supplement 2."

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5101:3-3-18      **Inpatient services: application of medicare upper payment limit calculation (MUPLC) for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).**

Prospective per diem rates calculated under rules 5101:3-3-43 and 5101:3-3-78 of the Administrative Code for NFs and ICFs-MR which participate in the medical assistance program shall not exceed, in the aggregate by scope specified in this rule, the amount that can reasonably be estimated to have been paid under medicare payment principles. The MUPLC for inpatient services provided by NFs and ICFs-MR is calculated as follows:

(A) The MUPLC applies to rates set by the Ohio department of job and family services (ODJFS) to pay for inpatient services furnished by NFs and ICFs-MR within one of the following categories:

(1) State government-owned or operated facilities i.e., all facilities that are either owned or operated by the state.

(2) Non-State government-owned or operated facilities i.e., all government facilities that are neither owned nor operated by the state.

(3) Privately-owned and operated facilities.

(B) Aggregate Medicaid payments to a group of facilities within one of the categories described in paragraph (A) of this rule may not exceed a reasonable estimate of the amount that would be paid for the services furnished by the group of facilities under Medicare payment principles.

~~5101:3-3-19      **Relationship of other covered medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services.**~~

~~This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the rules governing such reimbursement are set forth in Sections 5101:3-3-20, 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4 of ICF-MR Supplement 2, Attachment 4.19D. All references to "ICFs-MR" in paragraphs (A) to (I) of this rule do not include state operated ICFs-MR for which reimbursement is made in accordance with rule 5101:3-3-99 of the Administrative Code.~~

~~(A) Dental services.~~

~~All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Attachment 4.19B. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.~~

~~(B) Laboratory and x-ray services.~~

~~Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Attachment 4.19B.~~

~~(C) Medical supplier services.~~

~~Certain medical supplier services are reimbursable through the facility's cost report mechanism and others directly to the medical supply provider as follows:~~

~~(1) Items that must be reimbursed through the facility's cost report include:~~

- ~~(a) Costs incurred for "needed medical and program supplies" defined as those items that have a very limited life expectancy, such as, atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.~~

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- ~~(b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for the use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive pressure breathing machines, except as noted in paragraph (C)(2) of this rule.~~
- ~~(c) Costs of equipment associated with oxygen administration, such as, carts, regulators/humidifiers, cannulas, masks, and demurrage.~~
- ~~(2) Services that are reimbursed directly to the medical supplier provider, in accordance with Attachment 4.19B, include:~~
  - ~~(a) Certain durable medical equipment items, specifically, ventilators, and custom-made wheelchairs that have parts which are actually molded to fit the recipient.~~
  - ~~(b) "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.~~
  - ~~(c) "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.~~
  - ~~(d) Contents of oxygen cylinders or tanks, including liquid oxygen, except emergency stand-by oxygen which is reimbursed through the facility cost report mechanism.~~
  - ~~(e) Oxygen producing machines (concentrators) for specific use by an individual recipient.~~

~~(D) Pharmaceuticals:~~

- ~~(1) Over the counter drugs not listed in appendix A of rule 5101:3-9-12 of the Administrative Code, for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost report mechanism.~~

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- ~~(2) Pharmaceuticals reimbursable directly to the pharmacy provider are subject to the limitations found in Attachment 4.19B, the limitations established by the Ohio state board of pharmacy, and the following conditions:~~
- ~~(a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.~~
- ~~(b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF or an ICF MR must be signed by the facility representative at the time of delivery and a copy retained by pharmacy.~~
- ~~(E) Physical therapy, occupational therapy, speech therapy, audiology services, psychologist services, and respiratory therapy services:~~
- ~~(1) For NFs, the costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are reimbursed directly to the NF as specified in Attachment 4.19B. The costs incurred for these services provided by nursing staff of the NF are reimbursable through the facility cost report mechanism as specified in rule 5101:3-3-46.1 of the Administrative Code. Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the NF, ICF MR, or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the NF or ICF MR.~~
- ~~(2) For ICFs MR, the costs incurred for physical therapy, occupational therapy, speech therapy, audiology services, psychology services and respiratory therapy services provided by licensed therapists or therapy assistants or provided by licensed psychologists or psychology assistants and that are covered for ICF MR residents either by medicare or medicaid, are reimbursable through the facility cost report mechanism. Reasonable costs for rehabilitative, restorative, or~~

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~~maintenance therapy services rendered to facility residents by contracted staff or facility staff and the overhead costs to support the provision of such services are reimbursable through the rate determined in accordance with sections 5111.20 to 5111.33 of the Revised Code. Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the NF, ICF-MR, or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the NF or ICF-MR.~~

~~(F) Physician services.~~

~~(1) A physician may be directly reimbursed for the following services provided to a resident of a NF or ICF-MR by a physician:~~

~~(a) All covered diagnostic and treatment services in accordance with Attachment 4.19B.~~

~~(b) All medically necessary physician visits in accordance with Attachment 4.19B.~~

~~(c) All required physician visits as described in paragraphs (F)(1)(c)(i) to (F)(1)(c)(iv) of this rule when the services are billed in accordance with Attachment 4.19B.~~

~~(i) Physician visits must be provided to a resident of a NF or ICF-MR and must conform to the following schedule:~~

~~(a) For nursing facilities, the resident must be seen by a physician at least once every thirty days for the first ninety days after admission, and at least once every ninety days, thereafter.~~

~~(b) A physician visit is considered timely if it occurs not later than ten days after the date the visit was required.~~

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~~(ii) For reimbursement of the required physician visits, the physician must:~~

~~(a) Review the resident's total program of care including medications and treatments, at each visit required by paragraph (F)(1)(c)(i) of this rule;~~

~~(b) Write, sign, and date progress notes at each visit;~~

~~(c) Sign all orders; and~~

~~(d) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.~~

~~(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician and visits by physician assistant or certified nurse practitioner.~~

~~(iv) Physician delegation of tasks.~~

~~(a) A physician may delegate tasks to a physician assistant or certified nurse practitioner as defined by Chapter 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code for physician assistants, and Chapter 4723. of the Revised Code and Chapter 4723-4 of the Administrative Code for certified nurse practitioners who are in compliance with the following criteria:~~

~~(i) Are acting within the scope of practice as defined by state law; and~~

~~(ii) Are under supervision and employment of the billing physician.~~

~~(b) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.~~

~~(2) Services directly reimbursable to the physician must:~~

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~~(a) Be based on medical necessity, as defined in rule 5101:3-1-01 of the Administrative Code, and requested by the NF or ICF-MR resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and~~

~~(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the physician.~~

~~(3) Services provided in the capacity of overall medical direction are reimbursable only to a NF or ICF-MR and may not be directly reimbursed to a physician.~~

~~(G) Podiatry services.~~

~~Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Attachment 4.19B. Payment by ODJFS is limited to one visit per month for residents in a NF or ICF-MR setting.~~

~~(H) Transportation services.~~

~~Costs incurred by the facility for transporting residents by means other than covered ambulance or ambulette services are reimbursable through the facility cost report mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Attachment 4.19B.~~

~~(I) Vision care services.~~

~~All covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Attachment 4.19B.~~

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5101:3-3-19.1 Relationship of other covered medicaid services to intermediate care facility for the mentally retarded (ICF-MR) services.

This rule identifies covered services generally available to medicaid recipients and describes the relationship of such services to those provided by an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement are set forth in sections 5101:3-3-20, 5101:3-3-71, 5101:3-3-71.1, 5101:3-3-71.2, 5101:3-3-71.3, and 5101:3-3-71.4 of ICF-MR Supplement 2, Attachment 4.19D of the state plan. All references to "ICFs-MR" in paragraphs (A) to (I) of this rule do not include state-operated ICFs-MR for which reimbursement is made in accordance with section 5101:3-3-99 of Attachment 4.19D of the state plan.

(A) Dental services.

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Attachment 4.19B of the state plan. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.

(B) Laboratory and x-ray services.

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Attachment 4.19B of the state plan.

(C) Medical supplier services.

Certain medical supplier services are reimbursable through the facility's cost report mechanism and others directly to the medical supply provider as follows:

(1) Items that must be reimbursed through the facility's cost report include:

- (a) Costs incurred for "needed medical and program supplies" defined as those items that have a very limited life expectancy, such as, atomizers, nebulizers, bed pans, catheters, electric pads,

hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.

- (b) Costs incurred for "needed medical equipment" (and repair of such equipment), defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for the use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive-pressure breathing machines, except as noted in paragraph (C)(2) of this rule.
- (c) Costs of equipment associated with oxygen administration, such as, carts, regulators/humidifiers, cannulas, masks, and demurrage.
- (2) Services that are reimbursed directly to the medical supplier provider, in accordance with Attachment 4.19B of the state plan, include:
  - (a) Certain durable medical equipment items, specifically, ventilators, and custom-made wheelchairs that have parts which are actually molded to fit the recipient.
  - (b) "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.
  - (c) "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.
  - (d) Contents of oxygen cylinders or tanks, including liquid oxygen, except emergency stand-by oxygen which is reimbursed through the facility cost report mechanism.
  - (e) Oxygen producing machines (concentrators) for specific use by an individual recipient.

(D) Pharmaceuticals.

- (1) Over-the-counter drugs not listed in appendix A of rule 5101:3-9-12 of the

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Administrative Code, for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.

(2) Pharmaceuticals reimbursable directly to the pharmacy provider are subject to the limitations found in Attachment 4.19B of the state plan, the limitations established by the Ohio state board of pharmacy, and the following conditions:

(a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.

(b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy.

(E) Physical therapy, occupational therapy, speech therapy, audiology services, psychologist services, and respiratory therapy services.

For ICFs-MR, the costs incurred for physical therapy, occupational therapy, speech therapy, audiology services, psychology services and respiratory therapy services provided by licensed therapists or therapy assistants or provided by licensed psychologists or psychology assistants and that are covered for ICF-MR residents either by medicare or medicaid, are reimbursable through the facility cost report mechanism. Reasonable costs for rehabilitative, restorative, or maintenance therapy services rendered to facility residents by contracted staff or facility staff and the overhead costs to support the provision of such services are reimbursable through the rate determined in accordance with Attachment 4.19D of the state plan. Costs incurred for the services of a licensed psychologist are reimbursable through the facility cost report mechanism. No reimbursement for psychologist services shall be made to a provider other than the ICF-MR, or a community mental health center certified by the Ohio department of mental health. Services provided by an employee of the community mental health center must be billed directly to medicaid by the community mental health center. Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the facility

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cost report mechanism. No reimbursement for respiratory therapy services shall be made to a provider other than the ICF-MR.

(F) Physician services.

(1) A physician may be directly reimbursed for the following services provided to a resident of an ICF-MR by a physician:

(a) All covered diagnostic and treatment services in accordance with Attachment 4.19B of the state plan.

(b) All medically necessary physician visits in accordance with Attachment 4.19B of the state plan.

(c) All required physician visits as described in this rule when the services are billed in accordance with Attachment 4.19B of the state plan.

(i) Physician visits must be provided to a resident of an ICF-MR and are considered timely if they occur not later than ten days after the date the visit was required.

(ii) For reimbursement of the required physician visits, the physician must:

(a) Review the resident's total program of care including medications and treatments, at each visit required by this rule;

(b) Write, sign, and date progress notes at each visit;

(c) Sign all orders; and

(d) Personally visit (see) the patient except as provided in paragraph (F)(1)(c)(iii) of this rule.

(iii) At the option of the physician, required visits after the initial visit may be delegated in accordance with paragraph (F)(1)(c)(iv) of this rule and alternate between physician

and visits by physician assistant or certified nurse practitioner.

(iv) Physician delegation of tasks.

(a) A physician may delegate tasks to a physician assistant or certified nurse practitioner as defined by Chapter 4730. of the Revised Code and Chapter 4730-1 of the Administrative Code for physician assistants, and Chapter 4723. of the Revised Code and Chapter 4723-4 of the Administrative Code for certified nurse practitioners who are in compliance with the following criteria:

(i) Are acting within the scope of practice as defined by state law; and

(ii) Are under supervision and employment of the billing physician.

(b) A physician may not delegate a task when regulations specify that the physician must perform it personally, or when delegation is prohibited by state law or the facility's own policies.

(2) Services directly reimbursable to the physician must:

(a) Be based on medical necessity, as defined in rule 5101:3-1-01 of the Administrative Code, and requested by the ICF-MR resident with the exception of the required visits defined in paragraph (F)(1)(c) of this rule; and

(b) Be documented by entries in the resident's medical records along with any symptoms and findings. Every entry must be signed and dated by the physician.

(3) Services provided in the capacity of overall medical direction are reimbursable only to an ICF-MR and may not be directly reimbursed to a physician.

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(G) Podiatry services.

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Attachment 4.19B of the state plan. Payment by ODJFS is limited to one visit per month for residents in an ICF-MR setting.

(H) Transportation services.

Costs incurred by the facility for transporting residents by means other than covered ambulance or ambulette services are reimbursable through the facility cost report mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Attachment 4.19B of the state plan.

(I) Vision care services.

All covered vision care services, including examinations, dispensing, and the fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Attachment 4.19B of the state plan.

5101:3-3-20

As a condition of participation in the Title XIX medicaid program, each NF and ICF-MR shall file a cost report with the Ohio department of job and family services (ODJFS). The cost report, JFS 02524N "Medicaid Nursing Facility Cost Report" (~~rev. 01/2007~~)(Rev. 1/2010) as found in appendix A rule 5101:3-3-42.1 of the Administrative Code for NFs, and JFS 02524 "Medicaid ICF-MR Cost Report" (Rev. 01/2007) as found in appendix A rule 5101:3-3-71.1 of the Administrative Code for ICFs-MR, including its supplements and attachments as specified under paragraphs (A) to (L) of this rule or other approved forms for state-operated ICFs-MR, must be filed electronically within ninety days after the end of the reporting period. Except as specified under paragraph (E) of this rule, the report shall cover a calendar year or the portion of a calendar year during which the NF or ICF-MR participated in the medicaid program. In the case of a NF or ICF-MR that has a change of operator during a calendar year, the report by the new provider shall cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December thirty-first, except as specified under paragraph (G) of this rule. In the case of a NF or ICF-MR that begins participation after January first and ceases participation before December thirty-first of the same calendar year, the reporting period shall be the first day of participation to the last day of participation. ODJFS shall issue the appropriate software and an approved list of vendors for an electronically submitted cost report no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state-operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in rules 5101:3-3-42 and 5101:3-3-71 of the Administrative Code respectively, or relate its chart of accounts directly to the cost report.

- (A) For good cause, as deemed appropriate by ODJFS, cost reports may be submitted within fourteen days after the original due date if written approval from ODJFS is received prior to the original due date of the cost report. Requests for extensions must be in writing and explain the circumstances resulting in the need for a cost report extension.
- (1) For purposes of this rule, "original due date" means each facility's cost report is due ninety days after the end of each facility's reporting period. Unless waived by ODJFS, the reporting period ends as follows:
- (a) On the last day of the calendar year for the health care facility's year end cost report, except as provided in a paragraph (G)(2) of this rule; or

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- (b) On the last day of medicaid participation or when the facility closes in accordance with rule 5101:3-3-02(A)(1) of the Administrative Code; or
- (c) On the last day before a change of operator; or
- (d) On the last day of the new facility's or new provider's first three full calendar months of participation under the medicaid program which encompasses the first day of medicaid participation.
- (2) If a facility does not submit the cost report within fourteen days after the original due date, or by the extension date granted by ODJFS or submits an incomplete or inadequate report, ODJFS shall provide immediate written notice to the facility that its provider agreement will be terminated in thirty days unless the facility submits a complete and adequate cost report within thirty days of receiving the notice.
- (3) During the thirty day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, For for each day thea complete and adequate cost report is submitted after its original due date not received, the provider shall be assessed a late file penalty. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by the penalty. The penalty shall be two dollars per patient day adjusted each July first for inflation during the preceding twelve months as stated in division (A)(2) of section 5111.26 of the Revised Code. The late file penalty period will begin the day after the cost report's due date the date ODJFS issues its written notice and continue until the complete and adequate cost report is received by ODJFS or the facility is terminated from the medicaid program. The late file penalty shall be a reduction to the medicaid payment. No penalty shall be imposed during a fourteen-day extension granted by ODJFS as specified in paragraph (A) of this rule.
- (B) An "Addendum for Disputed Costs" shall be an attachment to the cost report that a NF or ICF-MR may use to set forth costs the facility believes may be disputed by ODJFS. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the cost report and/or chart of accounts for the cost report period in question (either in the reimbursable or the nonreimbursable cost centers). Any costs reported by the facility on the addendum may be considered by ODJFS in establishing the facility's prospective rate.

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- (C) ODJFS shall conduct a desk review of each cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. Before issuing the determination ODJFS shall notify the facility of any information on the cost report that requires further support. The facility shall provide any documentation or other information requested by ODJFS and may submit any information that it believes supports the reported costs. ODJFS shall notify each NF and ICF-MR of any costs preliminarily determined not to be allowable and provide the reasons for the determination.
- (1) The desk review is an analysis of the provider's cost report to determine its adequacy, completeness, and accuracy and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.
  - (2) A facility may revise the cost report within sixty days after the original due date without the revised information being considered an amended cost report.
  - (3) The cost report is considered accepted after the cost report has passed the desk review process.
  - (4) After final rates have been issued, a provider who disagrees with a desk review decision may request a rate reconsideration.
- (D) During the time when a cost report is open for audit, the provider may amend the cost report upon discovery of a material error or material additional information, ~~that increases or decreases the total per diem cost of the applicable cost center or rate by ten cents per patient day or greater. If the error or additional information would change the per diem cost or rate by less than ten cents per patient day, the provider may not, amend the cost report.~~ ODJFS shall not charge interest under division (B) of section 5111.28 of the Revised Code based on any error or additional information that is not required to be reported under this paragraph. ODJFS shall review the amended cost report for accuracy and notify the provider of its determination in accordance with section 5111.27 of the Revised Code. Since the audit determines reasonable and allowable costs, a cost report cannot be amended once an audit has been completed. However, should subsequent events occur or information become available to the provider after the audit is completed that affects the costs for the cost-reporting period, such information may be submitted to ODJFS if the final settlement of the cost report period has not been adjudicated.

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- (E) The annual cost report submitted by state-operated facilities shall cover the twelve-month period ending June thirtieth of the preceding year, or portion thereof, if medicaid participation was less than twelve months.
- (F) Cost reports submitted by county and state-operated facilities may be completed on accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.
- (G) Three-month cost reports:
- (1) Facilities and providers new to the medicaid program shall submit a cost report pursuant to paragraph (A)(1) of this rule for the period which includes the date of certification and subsequent three full calendar months of operations. The new provider of a facility that has a change of operator, on or after the effective date of this amendment shall submit a cost report within ninety days after the end of the facility's first three full calendar months after the change of operator.
  - (2) If a facility described in paragraph (G)(1) of this rule opens or changes operators on or after October second, the facility is not required to submit a year end cost report for that calendar year.
- (H) Providers are required to identify all known related parties as set forth under paragraph (BB) of rule 5101:3-3-01 of the Administrative Code.
- (I) Providers are required to identify all of the following:
- (1) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership as set forth under paragraphs (BB) and (CC) of rule 5101:3-3-01 of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the facility. When the facility or the common owner is a publicly owned and traded corporation, this information beyond basic identifying criteria is not required as part of the cost report but must be available within two weeks when requested. Publicly disclosed information must be available at the time of the audit; and
  - (2) Each corporate officer or director, if the provider is a corporation; and
  - (3) Each partner, if the provider is a partnership; and

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- (4) Each provider, whether participating in the medicare or medicaid program or not, which is part of an organization which is owned, or through any other device controlled, by the organization of which the provider is a part; and
- (5) Any director, officer, manager, employee, individual, or organization having direct or indirect ownership or control of five per cent or more [see paragraph (H) of this rule], or who has been convicted of or pleaded guilty to a civil or criminal offense related to his involvement in programs established by Title XVIII (medicare), Title XIX (medicaid), or Title XX (social services) of the Social Security Act, as amended (through 1/1/07); and
- (6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (H) of this rule, in a managerial, accounting, auditing, legal, or similar capacity who was employed by ODJFS, the Ohio department of health, the office of attorney general, the Ohio department of aging, the Ohio department of mental retardation and developmental disabilities, the Ohio department of commerce or the industrial commission of Ohio within the previous twelve months.
- (J) Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is ten thousand dollars or more in a twelve-month period; or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is ten thousand dollars or more in a twelve-month period, the audit provisions of 42 C.F.R. 420 subpart (D) (effective 12/30/82), apply to these contractors.
- (1) For purposes of this rule, "contract for service" is defined as the component of a contract that details services provided exclusive of supplies and equipment. It includes any contract which details services, supplies and equipment to the extent the value of the service component is ten thousand dollars or more within a twelve-month period.
- (2) For purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, who contract with a provider to supply a service, either to the provider or directly to the beneficiary, where medicaid reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is ten thousand dollars or more in a twelve-month period.

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- (K) Financial, statistical and medical records (which shall be available to ODJFS and to the U.S. department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODJFS issues an audit report, or six years after all appeal rights relating to the audit report are exhausted.
- (1) Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages of the greater amount:
- (a) One thousand dollars per audit; or
  - (b) Twenty-five per cent of the amount by which the undocumented cost increased the medicaid payments to the provider, during the fiscal year.
- (2) Failure to retain the required financial, statistical, or medical records to the extent that filed cost reports are unauditible shall result in the penalty as specified in paragraph (K)(1) of this rule. Providers whose records have been found to be unauditible will be allowed sixty days to provide the necessary documentation. If, at the end of the sixty days, the required records have been provided and are determined auditible, the proposed penalty will be withdrawn. If ODJFS, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditible, ODJFS shall impose the penalty as specified in paragraph (K)(1) of this rule.
- (3) Refusing legal access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (K)(1) of this rule for outstanding medical services until such time as the requested information is made available to ODJFS.
- (4) All requested financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for facilities certified for participation in the medicaid program by this state within at least sixty days after request by the state or its subcontractors. The preferred Ohio location is the facility itself, but may be a corporate office, an accountant's office, or an attorney's office elsewhere in Ohio. This requirement, however, does not preclude the state or its subcontractors from the option of conducting the audit and/or a review at the site of such records if outside of Ohio.

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(L) When completing cost reports, the following guidelines shall be used to properly classify costs:

- (1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two years or more, is to be reported in the capital cost component set forth under the Administrative Code. The costs of equipment acquired by an operating lease, including vehicles, executed before December 1, 1992, may be reported in the ancillary/support cost component for NFs and indirect care cost component for ICFs-MR if the costs were reported as administrative and general costs on the facility's cost report for the reporting period ending December 31, 1992, until the current lease term expires. The costs of any equipment leases executed before December 1, 1992 and reported as capital costs, shall continue to be reported under the capital cost component. The costs of any new leases for equipment executed on or after December 1, 1992, shall be reported under the capital costs component. Operating lease costs for equipment, which result from extended leases under the provision of a lease option negotiated on or after December 1, 1992, shall be reported under the capital cost component.
- (2) Except for employers' share of payroll taxes, workers compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost centers shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expended under separate cost centers if performed by separate staff may be expended to separate cost centers based upon documented hours worked, provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide for the remainder of the shift may be expended to separate cost centers provided the facility maintains adequate documentation of hours worked in each cost center.
- (3) The costs of resident transport vehicles are reported under the capital cost component. Maintenance and repairs of these vehicles is reported under the ancillary/support cost component for NFs and the indirect care cost component for ICFs-MR.

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5101:3-3-21      **Audits of nursing facilities (NFS) and intermediate care facilities  
for the mentally retarded (ICFS-MR).**

(A) The Ohio department of ~~human services (ODHS)~~ job and family services (ODJFS) may conduct audits of the ~~ODHS-2524~~ JFS 02524 medicaid NF and ICF-MR cost report in accordance with Chapter 119. of the Revised Code, and shall notify the NF or ICF-MR of its audit findings.

(1) Until an audit is conducted or until three years have elapsed since the cost report was filed with ~~ODHS~~ ODJFS, whichever is earlier, a facility may amend the cost report as set forth in the final rate recalculation provision pursuant to section 5111.28 of the Revised Code and rule 5101:3-3-20 of the Administrative Code. The amended cost report shall be submitted to ~~ODHS~~ ODJFS in duplicate on the appropriate ~~ODHS-2524~~ JFS 02524 cost report forms.

(2) ~~ODHS~~ ODJFS may establish a contract for the auditing of facilities by outside firms. Each contract entered into by bidding shall be effective for one to two years. ~~ODHS~~ ODJFS shall establish an audit manual and program which shall require that all field audits, conducted either pursuant to a contract or by ~~ODHS-~~ ODJFS employees:

(a) Comply with applicable rules prescribed pursuant to title XVIII and XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended; and

(b) Consider generally accepted auditing standards prescribed by the American institute of certified public accountants; and

(c) Include a written summary as to whether the costs included in the report examined during the audit are allowable and are presented fairly in accordance with generally accepted accounting principles and ~~ODHS-~~ ODJFS rules, whether in all material aspects, allowable costs are documented, reasonable, and related to patient care; and

(d) Are conducted by ~~ODHS~~ ODJFS employees or accounting firms who, during the period of the professional engagement or employment and during the period covered by the financial statements, do not have nor are committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a nursing facility or intermediate care facility for the mentally retarded in this state; and

(e) Are conducted by ~~ODHS~~ ODJFS employees or accounting firms who, as a condition of the contract or employment, shall not audit any facility that has been a client of the firm or an ~~ODHS~~ ODJFS employee; and

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- (f) Are conducted by ~~ODHS~~ODJFS employees or auditors who are otherwise independent as determined by the standards of independence established by the American institute of certified public accountants; and
  - (g) Are completed within the time period specified by ~~ODHS~~ODJFS; and
  - (h) Provide to the facility complete written interpretations which explain in detail the application of all relevant contract provisions, regulations, auditing standards, rate formulae, and ~~ODHS~~ODJFS policies, with explanations and examples, that are sufficient to permit the facility to calculate with reasonable certainty those costs that are allowable and the rate to which the facility is entitled.
- (B) ~~ODHS~~ODJFS shall prepare a written summary of any audit disallowance set forth in paragraph (A) of this rule. Where the facility is pursuing judicial and administrative remedies in good faith regarding the disallowance or finding, ~~ODHS~~ODJFS shall not withhold from the facility's current payments any amounts the department claims to be due from the facility set forth in the final rate recalculation provision pursuant to section 5111.28 of the Revised Code.

**5101:3-3-22 Rate recalculations, interest on overpayments, penalties, repayment of overpayments, and deposit of repayment of overpayments for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).**

(A) If the provider properly amends its cost report under rule 5101:3-3-20 of the Administrative Code, the Ohio department of job and family services (ODJFS) makes a finding based on an audit under rule 5101:3-3-21 of the Administrative Code, or ODJFS makes a finding based on an exception review of resident assessment information conducted under section 5111.27 of the Revised Code after the effective date of the rate for direct care costs that is based on the assessment information any of which results in a determination that the provider has received a higher rate than it was entitled to receive, ODJFS shall recalculate the provider's rate using the revised information. ODJFS shall apply the recalculated rate to the periods when the provider received the incorrect rate to determine the amount of the overpayment. The provider shall refund the amount of the overpayment. In addition to requiring a refund under this rule, ODJFS may charge the provider interest at the applicable rate specified in this rule from the time the overpayment was made.

(1) If the overpayment resulted from costs reported for calendar year 1993, the interest shall be no greater than one and one-half times the average bank prime rate.

(2) If the overpayment resulted from costs reported for subsequent calendar years:

(a) The interest shall be no greater than two times the average bank prime rate if the overpayment was equal to or less than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(b) The interest shall be no greater than two and one-half times the average bank prime rate if the overpayment was greater than one per cent of the total medicaid payments to the provider for the fiscal year for which the incorrect information was used to establish a rate.

(3) ODJFS shall determine the average bank prime rate using statistical release H.15, "Selected Interest Rates," a weekly publication of the federal reserve board, or any successor publication. If statistical release H.15, or its successor ceases to contain the bank prime rate information or ceases to be published, ODJFS shall request a written statement of the average bank prime rate from the federal reserve bank of Cleveland or the federal reserve board.

(B) ODJFS also may impose the following penalties:

TN# 06-010 Approval Date 05/17/07  
Supersedes  
TN# 02-010 Effective Date 07/01/06

5101:3-3-22

(1) If a provider does not furnish invoices or other documentation that ODJFS requests during an audit within sixty days after the request, no more than the greater of one thousand dollars per audit or twenty-five per cent of the cumulative amount by which the costs for which documentation was not furnished increased the total medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate;

(2) If an owner fails to provide notice of sale of the facility closure, voluntary withdrawal or voluntary termination of participation in the medical assistance medicaid program, or change of operator as required by rules 5101:3-3-51.6 and 5101:3-3-84.5 of the Administrative Revised Code, no more than the current average bank prime rate plus four per cent of the last two monthly payments.

(C) If the provider continues to participate in the medical assistance medicaid program, ODJFS shall deduct any amount that the provider is required to refund under this rule, and the amount of any interest charged or penalty imposed under this rule, from the next available payment from ODJFS to the provider. ODJFS and the provider may enter into an agreement under which the amount, together with interest, is deducted in installments from payments from ODJFS to the provider.

(D) ODJFS shall transmit refunds and penalties to the treasurer of state for deposit in the general revenue fund.

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Supersedes  
TN# 02-010 Effective Date 07/01/06

5101:3-3-24.1 **Rate adjustments for nursing facilities ~~(NFS)~~(NFs) and intermediate care facilities for the mentally retarded ~~(ICFS-MR)~~ (ICFs-MR): government mandates.**

A NF, ICF-MR, or a group or association of facilities may request adjustment of a prospective rate established under rules 5101:3-3-01 to 5101:3-3-99 of the Administrative Code to account for the reasonable, additional costs that must be incurred by a facility or facilities to comply with the requirements of a government mandate.

(A) A government mandate includes and is limited to the following:

- (1) Federal statutes, rules, or policies enacted or amended after January 1, 1992; and
- (2) State statutes, rules or policies enacted or amended after January 1, 1992; and
- (3) Orders issued by the state of Ohio fire authorities; and
- (4) Orders issued by the applicable local fire authorities.

(B) For orders issued by state or local fire authorities, the following provisions shall apply:

- (1) A rate adjustment shall be requested in accordance with the following procedures:
  - (a) The request for a rate adjustment shall be filed in writing; and
  - (b) The request for a rate adjustment shall be filed before the end of the fiscal year in which the rate is paid; and
  - (c) The request for a rate adjustment shall be addressed to ~~long-term care, office of medicaid, rate adjustments~~ "[Ohio Department of Jobs and Family Services, Ohio Health Plans, Bureau of Long Term Care Facilities, Reimbursement Section](#)"; and
  - (d) The request for a rate adjustment shall include a copy of the order of the state or local fire authorities; and
  - (e) The request for a rate adjustment shall include appropriate documentation of the costs that are incurred as a result of the government mandate. A three-month cost report covering the applicable cost center and reflecting the additional costs to be incurred must be filed in accordance with the following requirements:
    - (i) The three-month cost report filed must include a trial balance; and

- (ii) If the requested rate adjustment affects cost of ownership or renovations reimbursement, actual cost data for the three-month period immediately preceding the date the assets are placed in service must be reported on the three-month cost report. Capital costs must be restated to reflect the impact of the capital additions, using actual depreciation and amortization tables. The depreciation and amortization tables that support the information on the cost report shall be filed with the cost report. The computation restating capital costs shall be filed with the cost report; and
  - (iii) If the cost increase affects any other cost center, actual data must be filed on the three-month cost report.
- (2) A rate adjustment will not be granted if the additional costs to be incurred should have been incurred previously to comply with existing licensure and certification standards unless the facility can demonstrate a change in the ongoing interpretation of the applicable standard; and
  - (3) ~~ODHS~~ODJFS shall respond in writing to each request for a rate adjustment pursuant to paragraph (B) of this rule within sixty days of the receipt of the written request. If ~~ODHS~~ODJFS requests additional information to determine whether a rate adjustment is warranted, ~~ODHS~~ODJFS shall respond in writing within sixty days of the receipt of the additional information; and
  - (4) The effective date of a rate adjustment pursuant to paragraph (B) of this rule shall be determined at the discretion of ~~ODHS~~ODJFS, but no later than the first day of the first month after the reimbursable expenses begin to be incurred.
- (C) For government mandates which affect a specific class of ~~NF's~~NFs or ICFs-MR operating in the state of Ohio, the provisions set forth under paragraph (C) of this rule shall apply. For purposes of this rule, a "specific class of ~~NF's~~NFs or ~~ICF's-MR~~ICFs-MR" is a group of facilities with a common characteristic or set of characteristics that is the focus of the government mandate.
- (1) A rate adjustment shall be requested in accordance with the following procedures:
    - (a) The request for a rate adjustment shall be filed in writing; and
    - (b) The request for a rate adjustment shall be filed before the end of the fiscal year in which the rate is paid; and
    - (c) The request for a rate adjustment shall be addressed to ~~long term care, office of medicaid, rate adjustments~~ "Ohio Department of Jobs and Family

Services, Ohio Health Plans, Bureau of Long Term Care Facilities, Reimbursement Section"; and

- (d) The request for a rate adjustment shall include appropriate documentation of the legal requirement necessitating the rate adjustment. If the legal requirement is the result of a new federal or state statute or rule, a complete citation to the applicable provision or provisions shall constitute appropriate documentation of the legal requirement; and
  - (e) The request for a rate adjustment shall include appropriate documentation of the costs that are incurred as a result of the government mandate. This documentation shall detail actions to be taken in response to the government mandate, the relationship of these actions to the government mandate, and the costs of these actions.
- (2) A rate adjustment will not be granted if the additional costs to be incurred should have been incurred previously to comply with existing licensure and certification standards unless the facility can demonstrate a change in the ongoing interpretation of the applicable standard; and
  - (3) ~~ODHS~~ODJFS shall respond in writing to each request for a rate adjustment pursuant to paragraph (C) of this rule within sixty days of the receipt of the written request. If ~~ODHS~~ODJFS requests additional information to determine whether a rate adjustment is warranted, ~~ODHS~~ODJFS shall respond in writing within sixty days of the receipt of the additional information; and
  - (4) The effective date of a rate adjustment pursuant to paragraph (C) of this rule shall be determined at the discretion of ~~ODHS~~ODJFS.
- (D) The decision of the ~~ODHS~~ODJFS in response to a request for rate adjustment is subject to appeal to the director of ~~ODHS~~ODJFS within thirty days of notification to the provider or group of provider's of the decision made by ~~ODHS~~ODJFS. The decision of ~~ODHS~~ODJFS is not subject to appeal pursuant to Chapter 119. of the Revised Code.

5101:3-3-26      **Nursing facilities (NFs) and intermediate care facilities for the  
mentally retarded (ICFs-MR): implementation of timely rates.**

- (A) The department of ~~human services (ODHS)~~ job and family services (ODJFS) shall make its best efforts each year to calculate rates under Chapter 5101:3-3 of the Administrative Code in time to use them to make the payments due to NFs and ICFs-MR by the fifteenth day of August. If ~~ODHS~~ ODJFS is unable to calculate the rates so that they can be paid by that date, ~~ODHS~~ ODJFS shall pay each NF or ICF-MR the rate calculated for it under Chapter 5101:3-3 of the Administrative Code at the end of the previous fiscal year. If ~~ODHS~~ ODJFS also is unable to calculate rates to make the payments due by the fifteenth day of September and the fifteenth day of October, ~~ODHS~~ ODJFS shall pay the previous fiscal year's rate to make those payments. - ~~ODHS~~ ODJFS may increase by five per cent the previous fiscal year's rate paid to any NF or ICF-MR pursuant to this rule at the request of the NF or ICF-MR. ~~ODHS~~ ODJFS shall use rates calculated for the current fiscal year to make the payments due by the fifteenth day of November.
- (B) If the rate paid to a NF or ICF-MR pursuant to this rule is lower than the rate calculated for it for the current fiscal year, ~~ODHS~~ ODJFS shall pay the NF or ICF-MR the difference between the two rates for the number of days for which the NF or ICF-MR was paid pursuant to this rule. If the rate paid to a NF or ICF-MR pursuant to this rule is higher than the rate calculated for it for the current fiscal year, the NF or ICF-MR shall refund to ~~ODHS~~ ODJFS the difference between the two rates for the number of days for which the NF or ICF-MR was paid pursuant to this rule.

5101:3-3-71      **Intermediate care facilities for the mentally retarded (ICFs-MR):  
chart of accounts.**

- (A) The Ohio department of job and family services (ODJFS) requires that all facilities file cost reports annually to comply with section 5111.26 of the Revised Code.
- (1) The use of the chart of accounts in table 1 to table 8 of appendix A to this rule is recommended to establish the minimum level of detail to allow for cost report preparation.
  - (2) If the recommended chart of accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report.
  - (3) Where a chart of accounts number has sub-accounts, it is recommended that the sub-accounts capture the information requested so that the information will be broken out for cost reporting purposes.
  - (4) For example, when revenue accounts appear by payor type, it is required that those charges be reported by payor type where applicable; when salary accounts are differentiated between "supervisory" and "other", it is required that this level of detail be reported on the cost report where applicable.
- (B) While the chart of accounts facilitates the level of detail necessary for medicaid cost reporting purposes, providers may find it desirable or necessary to maintain their records in a manner that allows for greater detail than is contained in the recommended chart of accounts.
- (1) The recommended chart of accounts allows for a range of account numbers for a specified account.
  - (2) For example, account 1001 is listed for petty cash, with the next account, cash, beginning at account 1010. Therefore, a provider could delineate sub-accounts 1010-1, 1010-2, 1010-3, 1010-4, to 1010-9 as separate cash accounts. Providers need only use the sub-accounts applicable for their facility.
- (C) Within the expense section (tables 5, 6, and 7), accounts identified as "salary" accounts are only to be used to report wages for facility employees.

OCT - 6 2010

TN # 09-029 Approval Date \_\_\_\_\_

Supersedes

TN # 06-010 Effective Date 12/31/09

- (1) Wages are to include wages for sick pay, vacation pay and other paid time off, as well as any other compensation to be paid to the employee.
  - (2) Expense accounts identified as "contract" accounts are only to be used for reporting the costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll.
  - (3) Expense accounts identified as "purchased nursing services" are only to be used for reporting the costs incurred for personnel acquired through a nursing pool agency.
  - (4) Expense accounts designated as "other" can be used for reporting any appropriate non-wage expenses, including contract services and supplies.
- (D) Completion of the cost report as required in section 5111.26 of the Revised Code will require that the number of hours paid be reported (depending on facility type of control, on an accrual or cash basis) for all salary expense accounts. Providers' record keeping should include accumulating hours paid consistent with the salary accounts included within the recommended chart of accounts.

OCT - 6 2009

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TABLE 1

BALANCE SHEET ACCOUNTS-ASSETS

CURRENT ASSETS

1001 Petty Cash

1010 Cash in Bank

- 1010.1 - General Account
- 1010.2 - Payroll account
- 1010.3 - Savings account
- 1010.4 - Imprest cash funds
- 1010.5 - Certificates of deposit
- 1010.6 - Money market
- 1010.7 - Resident funds

These cash accounts represent the amount of cash deposited in banks or financial institutions.

1030 Accounts Receivable

- 1030.1 - Private
- 1030.2 - Medicare
- 1030.3 - Medicaid
- 1030.4 - Other Payors

The balances in these accounts represent the amounts due the LTCF for services delivered and/or supplies sold.

1040 Allowance for Uncollectible Accounts Receivable

This account represents the estimated amount of uncollectible receivables.

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1050 Notes Receivable

This account represents notes receivable due on demand, or that portion of notes due within twelve (12) months of the balance sheet date.

1060 Allowance for Uncollectible Notes Receivable

This account represents the estimated amount of uncollectible notes receivables.

1070 Other Receivables

- 1070.1 - Employees
- 1070.2 - Sundry

1080 Cost Settlements

- 1080.1 - Medicare
- 1080.2 - Medicaid

These accounts represent amounts due provider from current or prior unsettled cost reporting periods.

1090 Inventories

- 1090.1 - Medical and program supplies
- 1090.2 - Dietary
- 1090.3 - Gift shop
- 1090.4 - Housekeeping supplies
- 1090.5 - Laundry and linen
- 1090.6 - Maintenance

These accounts represent the cost of unused LTCF supplies.

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1100 Prepaid Expenses

- 1100.1 - Insurance
- 1100.2 - Interest
- 1100.3 - Rent
- 1100.4 - Pension plan
- 1100.5 - Service contract
- 1100.6 - Taxes
- 1100.7 - Other

These accounts represent payments for costs which will be charged to future accounting periods.

1110 Short - Term Investments

- 1110.1 - U.S. Government securities
- 1110.2 - Marketable securities
- 1110.3 - Other

1120 Special Expenses

- 1120.1 - Telephone systems
- 1120.2 - Prior authorized medical equipment

Unamortized cost of telephone systems and prior authorized medical equipment. Amortized cost of telephone systems acquired before 12/1/92, if the costs were reported as administrative and general on the facility's cost report for the period ending 12/31/92, should be reported in account 7225.

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1200 Property, Plant and Equipment

- 1200.1 - Land
- 1200.2 - Land improvements
- 1200.3 - Building and building improvements
- 1200.4 - Equipment
- 1200.5 - Transportation equipment
- 1200.6 - Leasehold improvements
- 1200.7 - Financing cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.
- 1200.18 - Assets under capital lease - prior to 5/27/92
- 1200.19 - Assets under capital lease - on or after 5/27/92

1250 Accumulated Depreciation and Amortization - Prop., Plant & Equip.

- 1250.1 - Land improvements
- 1250.2 - Building and building improvements
- 1250.3 - Equipment
- 1250.4 - Transportation equipment
- 1250.5 - Leasehold improvements
- 1250.6 - Financing cost-cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.
- 1250.15 - Assets under capital lease - prior to 5/27/92
- 1250.16 - Assets under capital lease - on or after 5/27/92

1300 Renovations

As defined in the Ohio Revised Code (ORC).

- 1300.1 - Building and building improvements
- 1300.2 - Equipment
- 1300.3 - Leasehold improvements
- 1300.4 - Financing Cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.
- 1300.9 - Assets under capital lease - prior to 5/27/92
- 1300.10 - Assets under capital lease - on or after 5/27/92

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1350 Accumulated Depreciation and Amortization - Renovations

- 1350.1 - Building and building improvements
- 1350.2 - Equipment
- 1350.3 - Leasehold improvements
- 1350.4 - Financing cost - cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.
- 1350.9 - Assets under capital lease - prior to 5/27/92
- 1350.10 - Assets under capital lease - on or after 5/27/92

OTHER ASSETS

1400 Non-Current Investments

- 1400.1 - Certificates of deposit
- 1400.2 - U.S. Government securities
- 1400.3 - Bank savings account
- 1400.4 - Marketable securities
- 1400.5 - Cash surrender value of insurance
- 1400.6 - Replacement reserve
- 1400.7 - Funded depreciation

1410 Deposits

- 1410.1 - Workers' compensation
- 1410.2 - Leases
- 1410.3 - Other

1420 Due From Owners/Officers

- 1420.1 - Officers
- 1420.2 - Owners

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1430 Deferred Charges and Other Assets

- 1430.1 - Escrow accounts
- 1430.2 - Deferred loan costs and finance charges except  
property, plant and equipment
- 1430.3 - Organization expenses
- 1430.4 - Goodwill
- 1430.5 - Start-up costs

1440 Notes Receivable - Long Term

This account represents notes receivable or portion thereof due more than  
twelve (12) months from balance sheet date.

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**TABLE 2**  
**BALANCE SHEET ACCOUNTS - LIABILITIES**

CURRENT LIABILITIES

2010 Accounts Payable

2010.1	-	Trade
2010.2	-	Resident deposits-private
2010.3	-	Resident funds

These accounts represent amounts due to vendors, creditors, and residents for services and supplies purchased, which are payable within one (1) year of the balance sheet date.

2020 Cost Settlements

2020.1	-	Medicare
2020.2	-	Medicaid

These accounts represent amounts due to medicare or medicaid from current or prior unsettled cost reporting periods.

2030 Notes Payable

2030.1	-	Notes payable - vendors
2030.2	-	Notes payable - bank
2030.3	-	Notes payable - other

These accounts represent amounts due vendors and banks, evidenced by promissory notes, payable on demand, or due within one year of the balance sheet date.

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2040 Current Portion of Long Term Debt

This account represents the principal of notes, loans, mortgages, capital lease obligations or bonds due within twelve (12) months of the balance sheet date.

2050 Accrued Compensation

- 2050.1 - Salaries and wages
- 2050.2 - Vacations
- 2050.3 - Sick leave
- 2050.4 - Bonuses
- 2050.5 - Pensions - retirements plans
- 2050.6 - Profit sharing plans

2060 Payroll Related Withholding and Liabilities

- 2060.1 - Federal income
- 2060.2 - FICA
- 2060.3 - State
- 2060.4 - Local income
- 2060.5 - Employer's portion of FICA/medicare taxes or OPERS
- 2060.6 - Group insurance premium
- 2060.7 - State unemployment taxes
- 2060.8 - Federal unemployment taxes
- 2060.9 - Worker's compensation
- 2060.10 - Union dues

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2080 Taxes Payable

2080.1	-	Real estate
2080.2	-	Personal property
2080.3	-	Federal income tax
2080.4	-	State income tax/franchise tax
2080.5	-	Local income tax
2080.6	-	Sales taxes
2080.7	-	Other taxes

2090 Other Liabilities

2090.1	-	Accrued interest
2090.2	-	Dividends payable
2090.3	-	Other
2090.4	-	Franchise permit fee

LONG TERM LIABILITIES

2410 Long Term Debt

2410.1	-	Mortgages
2410.2	-	Bonds
2410.3	-	Notes payable
2410.4	-	Construction loans
2410.5	-	Capital lease obligations
2410.6	-	Life insurance policy loan

These accounts reflect liabilities that have maturity dates extending beyond one (1) year after the balance sheet date.

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- 2420 Related Party Loans  
Interest allowable under medicare guidelines.
- 2430 Related Party Loans  
Interest non-allowable under medicare guidelines.
- 2440 Non-Interest Bearing Loans From Owners  
See the "Centers for Medicare and Medicaid Services (CMS) Publication 15-1," section 1210 (REV.11/05).
- 2450 Deferred Liabilities
  - 2450.1 - Revenue
  - 2450.2 - Federal income taxes
  - 2450.3 - State income taxes
  - 2450.4 - Local income taxes

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TABLE 3

**BALANCE SHEET ACCOUNT-CAPITAL**

This account represents the difference between total assets and total liabilities for the reporting entity. This account includes capital of for-profit entities and not-for-profit entities (fund balance). It also represents the net effect of all the transactions within account balances, including but not limited to contributions, distributions, transfers between funds and current year profit or loss. In addition, it represents capital stock and associated accounts.

3000 Capital

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**TABLE 4**

**REVENUE ACCOUNTS**

ROUTINE SERVICE REVENUES

- 5010 Room and Board - Private
- 5011 Room and Board - Medicare
- 5012 Room and Board - Medicaid
- 5013 Room and Board - Veterans
- 5014 Room and Board - Other

ANCILLARY SERVICE REVENUES

- 5020 Physical Therapy
- 5030 Occupational Therapy
- 5040 Speech Therapy
- 5050 Audiology Therapy
- 5060 Respiratory Therapy
- 5070 Medical Supplies - Medicare  
Items which are billable to medicare regardless of payor type.
  - 5070.1 - Medicare B-Medicaid
  - 5070.2 - Medicare B-Other
  - 5070.3 - Private
  - 5070.4 - Medicare A
  - 5070.5 - Veterans
  - 5070.6 - Other
  - 5070.7 - Medicaid
- 5080 Medical Supplies - Routine  
Medicaid allowable supplies which are not billable to medicare regardless of payor type.

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- 5090 Medical Minor Equipment - Medicare  
Items which are billable to medicare regardless of payor type.
- 5090.1 - Medicare B-Medicaid
  - 5090.2 - Medicare B-Other
  - 5090.3 - Private
  - 5090.4 - Medicare A
  - 5090.5 - Veterans
  - 5090.6 - Other
  - 5090.7 - Medicaid
- 5100 Medical Minor Equipment - Routine  
Medicaid allowable equipment which are not billable to medicare regardless of payor type.
- 5110 Enteral Nutrition Therapy - Medicare  
Items which are billable to medicare regardless of payor type.
- 5110.1 - Medicare B-Medicaid
  - 5110.2 - Medicare B-Other
  - 5110.3 - Private
  - 5110.4 - Medicare A
  - 5110.5 - Veterans
  - 5110.6 - Other
  - 5110.7 - Medicaid
- 5120 Enteral Nutrition Therapy - Routine  
Medicaid allowable enterals which are not billable to medicare regardless of payor type.
- 5130 Habilitation Supplies
- 5140 Incontinence Supply
- 5150 Personal Care
- 5160 Laundry Service - Routine

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OTHER SERVICE REVENUES

These accounts represent other charges for services as well as for certain services not covered by the medicaid program.

- 5310 Dry Cleaning Service
- 5320 Communications
- 5330 Meals
- 5340 Barber and Beauty
- 5350 Personal Purchases - Residents
- 5360 Radiology
- 5370 Laboratory
- 5380 Oxygen
- 5390 Legend Drugs
- 5400 Other, Specify

NON-OPERATING REVENUES

- 5510 Management Services
- 5520 Cash Discounts
- 5530 Rebates and Refunds
- 5540 Gift Shop
- 5550 Vending Machine Revenues
- 5555 Vending Machine Commissions
- 5560 Rental-Space
- 5570 Rental-Equipment
- 5580 Rental-Other
- 5590 Interest Income - Working Capital
- 5600 Interest Income - Restricted Funds
- 5610 Interest Income - Funded Depreciation
- 5620 Interest Income - Related Party Revenue
- 5625 Interest Income - Contributions
- 5630 Endowments
- 5640 Gain/Loss on Disposal of Assets
- 5650 Gain/Loss on Sale of Investments
- 5670 Unrestricted Contributions

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DEDUCTIONS FROM REVENUES

5710 Contractual Allowance - Medicare  
5720 Contractual Allowance - Medicaid

5730 Contractual Allowance - Other  
A single account which is the sum of 5710, 5720 and 5730 can be maintained by those LTCFs that do not record contractual allowances by payment source. Detail supporting this single account must be available.

5740 Charity Allowance

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TABLE 5

OTHER PROTECTED COST

MEDICAL SUPPLIES

Medical supplies - items which are disposable, or have a limited life expectancy, including but not limited to: atomizers and nebulizers, catheters, adhesive backed foam pads, eye shields, hypodermic syringes and needles. Routine nursing supplies such as: isopropyl alcohol, analgesic rubs, antiseptics, cotton balls and applicators, elastic support stockings, dressings (adhesive pads, abdominal pads, gauze pads and rolls, eye pads, stockinette), enema administration apparatus and enemas, hydrogen peroxide, glycerin swabs, lubricating jellies (Vaseline, KY Jelly, etc.), plastic or adhesive bandages (e.g. Band-Aids), medical tape, tongue depressors, tracheotomy care sets and suction catheters, tube feeding sets and component supplies, over the counter drugs, etc. (excludes incontinence supplies, enterals, and all items that are directly billed by supplier to medicare and medicaid.)

For those facilities participating in medicaid and not in medicare, all medical supplies are to be classified in account 6001. For those facilities participating in both the medicare and medicaid programs, medical supplies must be categorized and classified as follows:

- 6000 Medical Supplies Billable to Medicare  
Medical supplies for facilities participating in medicare which are billable to medicare regardless of payor type.
- 6001 Medical Supplies Non-Billable to Medicare  
Medical supplies for facilities not participating in medicare, as well as medical supplies for facilities which are not billable to medicare regardless of payor type.
- 6003 Oxygen  
Oxygen defined as emergency stand-by oxygen only; all other oxygen should be directly billed by supplier to medicaid.

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MEDICAL MINOR EQUIPMENT

Medical minor equipment limited to: enteral pumps, bed cradles, headgear, heat cradles, hernial appliances, splints, traction equipment, hypothermia or hyperthermia blankets, egg crate mattresses, and gel cushions. Medical equipment that does not qualify for the facility asset capitalization policy and is not included in this group should be reported in minor equipment, account 7350.

For those facilities participating in medicaid and not in medicare, all medical minor equipment should be classified in account 6006. For those facilities participating in both the medicare and medicaid programs, medical minor equipment must be categorized and classified as follows:

- 6005 Medical Minor Equipment Billable to Medicare  
Medical minor equipment for facilities participating in medicare which are billable to medicare regardless of payor type.
- 6006 Medical Minor Equipment Non-Billable to Medicare  
Medical minor equipment for facilities not participating in medicare, as well as medical minor equipment for facilities which are not billable to medicare regardless of payor type.

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UTILITY EXPENSES

6020 Heat, Light, Power  
Services provided to furnish heat, light and power. (This account does not include costs associated with on-site salaries or maintenance of heat, light, power.)

6030 Water and Sewage  
Services provided to furnish water and sewage treatment for facilities without on-site water and sewage plants. For facilities which have on-site water and sewer plants, this account includes the costs associated with the maintenance and repair of such operations, including the EPA test. The supplies are limited to: expendable water and sewage treatment and water softener supplies, which are used on the water and sewer system. Payroll taxes and fringe benefits should be reported under accounts 6054 and 6056, respectively.

6030.1 - Water and sewage salary  
6030.2 - Water and sewage other

6040 Trash and Refuse Removal  
Services provided to furnish trash and refuse removal, including grease trap removal fees. (This excludes housekeeping items such as trash bags.)

6050 Hazardous Medical Waste Collection  
Contract services provided to furnish hazardous waste collection bags, containers and removal service.

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PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT

6054 Payroll Taxes

Other protected payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05); and federal unemployment taxes (excludes purchased nursing).

6055 Workers Compensation

Other protected premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05) (excludes purchased nursing).

6056 Employee Fringe Benefits

Other protected fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144 (REV. 11/05). If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6057 EAP Administrator

An individual who performs the duties of the employee assistance program administrator for other protected personnel.

6057.1 - EAP administrator other protected salary

6057.2 - EAP administrator other protected contract

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6058 Self Funded Program Administrator  
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to other protected.)

- 6058.1 - Self funded admin. other protected salary
- 6058.2 - Self funded admin. other protected contract

6059 Staff Development  
Other protected continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with other protected personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

- 6059.1 - Staff development other protected salary
- 6059.2 - Staff development other protected contract

PROPERTY TAXES

- 6060 Real Estate Taxes  
Real property tax expense incurred by the provider.
- 6070 Personal Property Taxes  
Personal property tax expense incurred by the provider.
- 6080 Franchise Tax  
Allowable portion of franchise tax as defined in section 2122.4, of the "CMS Publication 15-1." (REV. 11/05)
- 6085 Commercial Activity Tax (CAT)  
Annual business privilege tax; begun July, 1, 2005.

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FRANCHISE PERMIT FEES

6091 Franchise Permit Fee

Franchise permit fee incurred by the provider. This is the franchise permit fee assessed by the Ohio department of job and family services (ODJFS) to intermediate care facilities for the mentally retarded (ICFs-MR) pursuant to the Ohio Administrative Code (OAC). ICFs-MR shall report one hundred percent of the ICFs-MR franchise permit fee in account 6091.

Franchise taxes are to be reported in account 6080, Franchise Tax.

HOME OFFICE COSTS

6095 Home Office Costs/Other Protected

Other protected expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to patient care and are limited to: utilities, real estate taxes, personal property tax, and franchise tax, and are allocated to the facility in accordance with "CMS Publication 15-1," section 2150 thru 2150.3, "Home Office Costs" (REV. 11/05).

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TABLE 6

DIRECT CARE COST CENTER

These accounts include costs that are specified and represent expenses related to the delivery of nursing and habilitation/rehabilitation services. The term "licensed" refers to state of Ohio licensure.

NURSING AND HABILITATION/REHABILITATION

6100 Medical Director  
A physician licensed under state law to practice medicine, that is responsible for the implementation of resident care policies, and the coordination of medical care in the facility.

- 6100.1 - Medical director salary
- 6100.2 - Medical director contract

6105 Director of Nursing  
A full time registered nurse who has, in writing, administrative authority, responsibility, and accountability for the functions, activities and training of the nursing services staff. (ICFs-MR are not required to have a full-time director of nursing.)

- 6105.1 - Director of nursing salary
- 6105.2 - Director of nursing contract

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6110 RN Charge Nurse  
A registered nurse (RN) designated by the director of nursing who is responsible for the supervision of the nursing activities in the facility.

- 6110.1 - RN charge nurse salary
- 6110.2 - RN charge nurse contract

6115 LPN Charge Nurse  
A licensed practical (vocational) nurse designated by the director of nursing who is responsible for the supervision of the nursing activities in the facility.

- 6115.1 - LPN charge nurse salary
- 6115.2 - LPN charge nurse contract

6120 Registered Nurse  
Salary of registered nurses providing direct nursing care to residents. This account does not include registered nurses from a nursing pool agency (purchased nursing).

- 6120.1 - Registered nurse salary
- 6120.2 - Registered nurse contract

6125 Licensed Practical Nurse  
Salary of licensed practical nurses providing direct nursing care to residents. This account does not include licensed practical nurses from a nursing pool agency (purchased nursing).

- 6125.1 - Licensed practical nurse salary
- 6125.2 - Licensed practical nurse contract

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6130 Nurse Aides

Salary of individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to: bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. This account does not include nurse aides from a nursing pool agency (purchased nursing). (Excludes housekeeping and laundry duties.)

6135 Activity Director

A professional, as required by the code of federal regulations, who oversees and is responsible for the activity program.

- 6135.1 - Activity director salary
- 6135.2 - Activity director contract

6140 Activity Staff

Personnel providing services related to the activity program.

- 6140.1 - Activity personnel salary
- 6140.2 - Activity personnel contract

6150 Program Specialist

Individuals who have a bachelor's degree, or course work, in areas of specialty such as recreation, art, dance, behavior management, music or physical education.

- 6150.1 - Program specialist salary
- 6150.2 - Program specialist contract

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6155 Program Director  
An individual to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan; must implement the active treatment or specialized service program defined by each resident's individual program plan; works directly with residents and with paraprofessional, nonprofessional and other professional program staff who work with residents.

- 6155.1 - Program director salary
- 6155.2 - Program director contract

6165 Habilitation Supervisor  
Supervisor with experience, training and background in habilitation.

- 6165.1 - Habilitation supervisor salary
- 6165.2 - Habilitation supervisor contract

6170 Habilitation Staff  
Personnel trained in habilitation who provide habilitation services.

- 6170.1 - Habilitation staff salary
- 6170.2 - Habilitation staff contract

6175 Psychologist  
A professional licensed under state law to practice psychology.

- 6175.1 - Psychologist salary
- 6175.2 - Psychologist contract

6180 Psychology Assistant  
An individual trained in psychology to assist the psychologist.

- 6180.1 - Psychology assistant salary
- 6180.2 - Psychology assistant contract

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- 6185 Respiratory Therapist  
A professional licensed under state law to render respiratory care.
- 6185.1 - Respiratory therapist salary
  - 6185.2 - Respiratory therapist contract
- 6190 Social Work/Counseling  
A professional licensed under state law to practice social work or counseling.
- 6190.1 - Social work/counseling salary
  - 6190.2 - Social work/counseling contract
- 6195 Social Services/Pastoral Care  
Personnel providing social services and/or pastoral services.
- 6195.1 - Social services/pastoral care salary
  - 6195.2 - Social services/pastoral care contract
- 6200 Qualified Mental Retardation Professional  
A professional with at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and is one of the following:
- (i) A doctor of medicine or osteopathy
  - (ii) A registered nurse
  - (iii) An individual who holds at least a bachelor's degree in a professional category specified in 42 CFR, Section 483.430, Paragraph (b)(5).  
(10-1-03 edition <http://www.gpoaccess.gov/cfr/index.html>)
- For QMRPs functioning as a QMRP and an administrator in an ICF-MR, report only the portion related to the cost of a QMRP.
- 6200.1 - QMRP salary
  - 6200.2 - QMRP contract

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- 6205 Quality Assurance  
Individuals providing the quality assurance functions in the facility, as overseen by the committee established under 42 CFR, Section 483.75 (O) (10-1-03 edition <http://www.gpoaccess.gov/cfr/index.html>). (Supplies are included in program supplies.) This account includes costs previously reported as utilization review personnel.
- 6210 Consulting and Management Fees  
Direct care consulting fees paid to a non-related entity pursuant to the OAC, necessary pursuant to CMS Pub. 15-1, Section 2135 (REV. 11/05), and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.
- 6215 Active Treatment Off-site Day Programming Services  
Active Treatment Day Programming Services are those services provided directly or through contract at a physical location other than in an area not certified by the director of health as an ICF-MR under Title XIX and regardless of whether or not the area in which the day programming is provided is less than two hundred feet away from the ICF-MR or whether or not the day programming is provided by an individual who, or organization that, is a related party to the provider of the ICF-MR. Active Treatment Day Programming Services are services that are part of a resident's individual plan that was developed by the resident interdisciplinary team under the supervision of the Qualified Mental Retardation Professional (QMRP). Active Treatment Day Programming Services may include, but are not limited to, employment support services, any other habilitative service, and any ancillary services provided while the residents are receiving the employment support services such as personal care, nursing, occupational therapy, physical therapy, psychology, social work/counseling, and transportation. Active Treatment Day Programming Services, reported under account number 6215 should not include services reported under other account numbers elsewhere in this cost report.

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6220 Other Direct Care Medical Services  
Direct care medical services not previously listed.

- 6220.1 - Other direct care salary
- 6220.2 - Other direct care contract

HOME OFFICE COSTS

6230 Home Office Costs/Direct Care  
Direct care expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to patient care and are limited to home office personnel functioning in place of the facility personnel in the nursing and habilitation/rehabilitation costs as specified in the direct care cost center, and are allocated to the facility in accordance with "CMS Publication 15-1," sections 2150 through 2150.3, "Home Office Costs" (REV. 11/05).

- 6230.1 - Home office/direct care salary
- 6230.2 - Home office/direct care other

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PURCHASED NURSING SERVICES

Expenses incurred by the facility to a nursing pool agency for temporary direct care personnel.

- 6300 Registered Nurse Purchased Nursing  
Registered nurses providing direct nursing care to residents.
- 6310 Licensed Practical Nurse Purchased Nursing  
Licensed practical nurses providing direct nursing care to residents.
- 6320 Nurse Aides Purchased Nursing  
Individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to: bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. (Excludes housekeeping and laundry duties.)

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DIRECT PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

This series represents payroll taxes, workers' compensation, fringe benefits, EAP administrator, self funded programs administrator and staff development for intermediate care facilities for the mentally retarded including ICFs-MR therapies.

6510 Payroll Taxes

Direct care payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05); and federal unemployment taxes (excludes purchased nursing).

6520 Workers' Compensation

Direct care premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05) (excludes purchased nursing).

6530 Employee Fringe Benefits

Direct care fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144 (REV. 11/05). If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6535 Employee Assistance Program Administrator - Direct Care

An individual who performs the duties of the employee assistance program administrator for direct care personnel.

- 6535.1 - EAP administrator direct care salary
- 6535.2 - EAP administrator direct care contract

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6540 Self Funded Programs Administrator - Direct Care  
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to direct care.)

6540.1 - Self funded admin. direct care salary  
6540.2 - Self funded admin. direct care contract

6550 Staff Development - Direct Care  
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with direct care personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

6550.1 - Staff development direct care salary  
6550.2 - Staff development direct care contract

DIRECT CARE THERAPIES

6600 Physical Therapist  
A qualified professional licensed under Ohio law as physical therapist.

6600.1 - Physical therapist salary  
6600.2 - Physical therapist contract

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- 6605 Physical Therapy Assistant  
An individual licensed under Ohio law as a physical therapy assistant.
- 6605.1 - Physical therapy assistant salary
  - 6605.2 - Physical therapy assistant contract
- 6610 Occupational Therapist  
A qualified professional licensed under Ohio law as an occupational therapist.
- 6610.1 - Occupational therapist salary
  - 6610.2 - Occupational therapist contract
- 6615 Occupational Therapy Assistant  
An individual licensed under Ohio law as an occupational therapy assistant.
- 6615.1 - Occupational therapy assistant salary
  - 6615.2 - Occupational therapy assistant contract
- 6620 Speech Therapist  
A qualified professional licensed under Ohio law as a speech therapist.
- 6620.1 - Speech therapist salary
  - 6620.2 - Speech therapist contract
- 6630 Audiologist  
A qualified professional licensed under Ohio law as an audiologist.
- 6630.1 - Audiologist salary
  - 6630.2 - Audiologist contract

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**TABLE 7**  
**INDIRECT CARE COST CENTER**

Indirect care costs includes costs other than direct care costs, other protected costs, or capital costs.

7000 Dietitian  
Service provided by a professional licensed under Ohio law, as qualified in the ORC.

- 7000.1 - Dietitian salary
- 7000.2 - Dietitian contract

7005 Food Service Supervisor  
An individual supervising the dietary procedures and/or personnel.

- 7005.1 - Food service supervisor salary
- 7005.2 - Food service supervisor contract

7015 Dietary Personnel  
Personnel providing dietary services. (Excludes dietitian, food service supervisor, and personnel reported in account 7050, contract personnel.)

- 7015.1 - Dietary personnel salary
- 7015.2 - Dietary personnel contract

7025 Dietary Supplies and Expenses  
Dietary items such as: dishes, dish-washing liquid, plastic wrap, cooking utensils, silverware and dietary supplies. (Excludes equipment or repairs as well as housekeeping items such as paper towels, trash bags, etc.)

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- 7030 Dietary Minor Equipment  
Dietary equipment which does not meet the facility's capitalization criteria specified under the OAC.
- 7035 Dietary Maintenance and Repair  
Maintenance supplies, purchased services and maintenance contracts for the dietary department.
- 7040 Food In-Facility  
Food required to prepare meals in the facility.
- 7045 Employee Meals  
Employee meals that do not qualify under "CMS Publication 15-1," section 2144 "Fringe Benefits" (REV. 11/05).
- 7050 Contract Meals and Contract Meals Personnel  
Expenses associated with contracting for the food service function in the facility. (Includes food services delivered to the facility from an outside vendor.)

For those facilities participating in medicaid and not in medicare, all enteral nutritional therapy and additives (food facilitators), whether administered orally or tube fed, are to be classified in account 7056. For those facilities participating in both the medicare and medicaid programs, enterals must be categorized and classified as follows:

- 7055 Enterals: Medicare Billable  
Enteral nutritional therapy and additive (food facilitators), whether administered orally or tube fed, for facilities participating in medicare which are billable to medicare regardless of payor type. Excludes peptamen enteral nutritional therapy that is directly reimbursed by medicaid (fee for service), as well as all parenteral nutrition therapy.

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7056 Enterals: Medicare Non-Billable  
Enteral nutritional therapy and additives (food facilitators), whether administered orally or tube fed, for facilities not participating in medicare, as well as enterals for facilities which are not billable to medicare regardless of payor type. Excludes peptamen enteral nutritional therapy that is directly reimbursed by medicaid (fee for services), as well as all parenteral nutrition therapy.

DIETARY PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

7060 Payroll Taxes - Dietary  
(series #7000) Payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS), state unemployment taxes or self insurance funds for unemployment compensation as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05), and federal unemployment taxes.

7065 Workers' Compensation - Dietary  
(series #7000) premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05).

7070 Employee Fringe Benefits - Dietary  
(series #7000) fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144 (REV. 11/05). If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes vacation and sick pay salary.)

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7075 Employee Assistance Program Administrator-Dietary  
(series #7000) an individual who performs the duties of the employee  
assistance program administrator for dietary personnel.

7075.1 - EAP administrator dietary salary  
7075.2 - EAP administrator dietary contract

7080 Self Funded Programs Administrator - Dietary  
(series #7000) an individual who performs the administrative functions of the  
self insured programs. (Report only the portion related to dietary.)

7080.1 - Self funded administrator dietary salary  
7080.2 - Self funded administrator dietary contract

7090 Staff Development - Dietary  
(series #7000) continuing training that enables the employee to perform his  
or her duties effectively, efficiently, and competently. Includes travel costs  
for individual's own vehicle, associated with dietary personnel for attending  
training. This account does not include expenses incurred for the use of a  
facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes  
only the trainer wages. "Other" costs include registration fees, travel and per  
diem expenses, training supplies and contract trainer fees.

7090.1 - Staff development dietary salary  
7090.2 - Staff development dietary other

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MEDICAL/HABILITATION, PHARMACEUTICAL AND INCONTINENCE  
SUPPLIES

7100 Habilitation Supplies

Supplies used to provide services measured by the individual assessment form (IAF), which assist the resident to cope with: daily living, aging process, and perform tasks normally performed at his/her chronological stage of development. Does not include cost of meals for out of facility functions.

7105 Medical/Habilitation Records

Personnel responsible for maintaining clinical records on each resident in accordance with accepted professional standards and practices.

7105.1 - Medical/habilitation records salary  
7105.2 - Medical/habilitation records contract

7110 Pharmaceutical Consultant

The services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility as stated in 42 CFR, Section 483.60(b).  
(10-1-03 edition <http://www.gpoaccess.gov/cfr/index.html>)

7110.1 - Pharmaceutical consultant salary  
7110.2 - Pharmaceutical consultant contract

7115 Incontinence Supplies

Reusable and disposable incontinence supplies (except catheters). Supplies include cloth or disposable diapers, under-pads, plastic pants, and the cost of diaper service of such items.

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- 7120 Personal Care  
Supplies required to maintain routine personal hygiene of the body, hair, and nails of the hands and feet. Includes body lotion, body powder, toothbrush and toothpaste, disposable razors and shaving supplies, hair cuts, shampoo and routine hair care supplies provided by facility. (Excludes contract beautician performing non-routine services.)
- 7125 Program Supplies  
Supplies used to provide activity, social services and religious programs available to all residents. Does not include cost of meals for out of facility functions.

ADMINISTRATIVE AND GENERAL SERVICES

- 7200 Administrator  
Expenses incurred by a facility for an individual(s) who functions as the administrator licensed by the state of Ohio and who is responsible for the direction, supervision and coordination of facility functions.

For ICFs-MR licensed by Ohio Department of Mental Retardation and Developmental Disabilities (ODMR-DD) who are not required to employ a licensed administrator, but have a QMRP functioning as the administrator, report only the portion related to the cost of an administrator.

- 7200.1 - Administrator salary
- 7200.2 - Administrator contract

- 7210 Other Administrative Personnel  
Administrator in training, assistant administrator, business manager, purchasing agent, human resources, receptionist, secretarial and clerical staff.

- 7210.1 - Other administrative salary
- 7210.2 - Other administrative contract

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- 7215 Consulting and Management Fees  
Indirect consulting fees paid to a non-related entity pursuant to the OAC, necessary pursuant to CMS Pub. 15-1, Section 2135 (REV. 11/05), and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.
  
- 7220 Office and Administrative Supplies  
Supplies such as: copier supplies, printing, postage, office supplies, nursing/habilitation and medical records forms, and data service supplies.
  
- 7225 Communications  
Service charges for telephone services.
  
- 7230 Security Services  
Salaries, purchased services, or supplies to protect property and residents.
  - 7230.1 - Security services salary
  - 7230.2 - Security services other
  
- 7235 Travel and Entertainment  
Expenses such as: mileage allowance, gas, and oil for vehicles owned or leased by the facility, meals, lodging, and commercial transportation expense incurred in the normal course of business. Includes all purchased commercial transportation services for ambulatory/non-ambulatory residents. Excludes transportation cost that is directly reimbursed by medicaid to the transportation provider as set forth in the OAC.

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- 7240 Laundry/Housekeeping Supervisor  
An individual supervising the laundry/housekeeping functions and/or personnel.
- 7240.1 - Laundry/housekeeping supervisor salary
  - 7240.2 - Laundry/housekeeping supervisor contract
- 7245 Housekeeping  
Housekeeping services, including supplies, wages, and purchased services. This includes trash bags and paper towels.
- 7245.1 - Housekeeping salary
  - 7245.2 - Housekeeping other
- 7250 Laundry and Linen  
Laundry services, including supplies, wages, and purchased services, as well as linens for all areas. Excluding incontinent supplies specified in account 7115.
- 7250.1 - Laundry/linen salary
  - 7250.2 - Laundry/linen other
- 7255 Universal Precaution Supplies  
Supplies required for the protection of residents and facility staff while performing procedures which involve the handling of bodily fluids. Supplies include: masks, gloves, gowns, goggles, boots, and eye wash. (Excludes trash bags and paper towels.)
- 7260 Legal Services  
Legal services except as excluded in the OAC.

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- 7265 Accounting  
Accounting, Bookkeeping Fees and Salaries.
- 7265.1 - Accounting salary
  - 7265.2 - Accounting contract
- 7270 Dues, Subscriptions and Licenses  
Expense of dues, subscriptions and licenses incurred by facility.
- 7275 Interest - Other  
Expense of short term credit and working capital interest incurred. (This account does not include late fees, fines or penalties.)
- 7280 Insurance  
Expense of insurance such as: general business, liability, malpractice, vehicle, and property insurance.
- 7285 Data Services  
Data services personnel and purchased services.
- 7285.1 - Data services salary
  - 7285.2 - Data services contract
- 7290 Help Wanted/Informational Advertising  
Help wanted ads, yellow pages, and other advertising media that are informational as opposed to promotional in nature as stated in "CMS Publication 15-1," section 2136.1 (REV. 11/05).
- 7295 Amortization of Start-Up Costs  
Amortization of cost included in the account 1430.5, not otherwise allocated to other cost centers, in accordance with "CMS Publication 15-1," section 2132 (REV. 11/05), which were incurred by a facility.

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- 7300 Amortization of Organizational Costs  
Amortization of cost included in account 1430.3, as described in "CMS Publication 15-1," section 2134 (REV. 11/05).
  
- 7305 Other Indirect Care Administrative Services - Specify below  
Indirect care administrative services not previously listed.
  - 7305.1 - Other indirect care salary
  - 7305.2 - Other indirect care contract

HOME OFFICE COSTS

- 7310 Home Office Costs/Indirect Care  
Indirect care expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to administrative and management services allocated to the facility in accordance with "CMS Publication 15-1," section 2150 through 2150.3, "Home Office Costs" (REV. 11/05).
  - 7310.1 - Home office/indirect care salary
  - 7310.2 - Home office/indirect care other

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MAINTENANCE AND MINOR EQUIPMENT

7320 Plant Operations and Maintenance Supervisor  
An individual supervising the plant operations and maintenance procedures and/or personnel.

- 7320.1 - Operations/maintenance supervisor salary
- 7320.2 - Operations/maintenance supervisor contract

7330 Plant Operations and Maintenance  
Salaries for all maintenance personnel employed by the facility.

7340 Repair and Maintenance  
Supplies, purchased services and maintenance contracts for all departments. (Excludes dietary maintenance account 7035 and on-site water and sewage account 6030.)

7350 Minor Equipment  
Equipment which does not meet the facility's capitalization criteria specified under rules of the OAC. The general characteristics are: comparatively small in size and unit cost, subject to inventory control, fairly large quantity is used, and generally, a useful life of approximately three years or less. (Exclude account 7030 - dietary minor equipment and items listed in accounts 6005 and 6006 - medical minor equipment.)

EQUIPMENT ACQUIRED BY OPERATING LEASE

7400 Lease Equipment  
This account includes the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992 (all leases effective after 12/01/92, should be reported in account 8065 for assets acquired prior to 7/01/93).

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INDIRECT PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT

7500 Payroll Taxes

Indirect care payroll related expenses incurred which are: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation ("CMS Publication 15-1," section 2122.6 REV. 11/05); and federal unemployment taxes.

7510 Workers' Compensation

Indirect care premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in "CMS Publication 15-1," section 2122.6 (REV. 11/05).

7520 Employee Fringe Benefits

Indirect care fringe benefits such as: medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in "CMS Publication 15-1," section 2144 (REV. 11/05). If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes vacation and sick pay salary.)

7525 Employee Assistance Program Administrator - Indirect Care

An individual who performs the duties of the employee assistance program administrator for indirect care personnel.

- 7525.1 - EAP administrator indirect care salary
- 7525.2 - EAP administrator indirect care contract

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7530 Self Funded Programs Administrator - Indirect Care  
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to indirect care.)

7530.1 - Self funded admin. indirect care salary  
7530.2 - Self funded admin. indirect care contract

7535 Staff Development - Indirect Care  
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with indirect care personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

7535.1 - Staff development indirect care salary  
7535.2 - Staff development indirect care other

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NON-REIMBURSABLE EXPENSES

- 9705 Legend Drugs
- 9710 Radiology
- 9715 Laboratory
  
- 9720 Oxygen  
See rule 5101:3-3-19.1 of the OAC. (This does not include emergency stand-  
by oxygen.)
  
- 9725 Other Non-Reimbursable - Specify Below:
  - 9725.1 - Other Non-Reimbursable salary
  - 9725.2 - Other Non-Reimbursable other
  
- 9730 Late Fees, Fines or Penalties  
(as stated in "CMS Publication 15-1") (REV. 11/05)
  
- 9735 Federal Income Tax
- 9740 State Income Tax
- 9745 Local Income Tax
  
- 9750 Insurance-Officer's life  
This is non-reimbursable expense when the facility is the beneficiary, except  
as referenced in "CMS Publication 15-1," section 2130 (REV. 11/05).
  
- 9755 Promotional Advertising and Marketing
  - 9755.1 - Promotional advertising/marketing salary
  - 9755.2 - Promotional advertising/marketing other
  
- 9760 Contributions and Donations  
"CMS Publication 15-1," section 608 (REV. 11/05).
  
- 9765 Bad Debt
- 9770 Parenteral Nutrition Therapy

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**TABLE 8**

**CAPITAL COST CENTER**

**COST OF OWNERSHIP  
PROPERTY, PLANT, EQUIPMENT AND EXTENSIVE RENOVATIONS**

Cost of ownership means the actual expense incurred for all of the following:

- (A) Depreciation and interest on any capital asset with a cost of five hundred dollars or more per item and a useful life of at least two (2) years. Provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the five hundred dollars criteria be exceeded.
  - (1) Buildings;
  - (2) Building improvements that are not approved as nonextensive renovations under section 5111.25 or 5111.251 of the Revised Code;
  - (3) Equipment;
  - (4) Extensive renovations;
  - (5) Transportation equipment;
- (B) Amortization and interest on land improvements and leasehold improvements;
- (C) Amortization of financing costs;
- (D) Lease and rent of land, building, and equipment that does not qualify for account 7400 leased equipment.



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RENOVATIONS COST CENTER

Renovation and extensive renovation mean any betterment, improvement, or restoration of intermediate care facility for the mentally retarded started before July 1, 1993, that meets the definition of a renovation or extensive renovation established in rules adopted by the department in effect on December 22, 1992. In the case of betterments, improvements, and restorations of intermediate care facilities for the mentally retarded started on or after July 1, 1993:

- (A) Renovation means the betterment, improvement, or restoration of an intermediate care facility for the mentally retarded beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed. A renovation may include betterment, improvement, restoration, or replacement of assets that are affixed to the building and have a useful life of at least five years. A renovation may include costs that otherwise would be considered maintenance and repair expenses if they are an integral part of the structural change that makes up the renovation project. Renovation does not mean construction of additional space for beds that will be added to a facility's licensed or certified capacity beyond its current functional capacity through a structural change.
- (B) Extensive renovation means a renovation that costs more than sixty-five per cent and no more than eighty-five per cent of the cost of constructing a new bed and that extends the useful life of the assets for at least ten years.

GROUP (A) ASSETS ACQUIRED

- 8010 Depreciation - Building and Building Improvements  
Depreciation of building and building improvements.
- 8020 Amortization - Land Improvements  
Amortization expense for land improvements.

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- 8030 Amortization - Leasehold Improvements  
Leasehold improvements are amortized over the remaining life of the lease or the useful life of the improvement, but no less than five years. However, if the useful life of the improvement is less than five years, it may be amortized over its useful life. Options on leases will not be considered in the computation for amortization of leasehold improvements.
- 8040 Depreciation - Equipment  
Depreciation expense for equipment.
- 8050 Depreciation - Transportation equipment  
Depreciation expense for transportation equipment.
- 8060 Lease and Rent - Building  
Expense incurred for lease and rental expenses relating to buildings. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation accounts.
- 8065 Lease and Rent - Equipment  
Expense incurred for lease and rental expenses relating to equipment. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation account. This account includes all leases effective after 12/01/92 for assets acquired prior to 7/01/93. (Cost of equipment, including vehicles, acquired by operating lease executed before 12/01/92, and the costs are reported as administrative and general on the facility's cost report for period ending 12/31/92 are to be reported in account 7400.)
- 8070 Interest Expense - Property, Plant and Equipment  
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for the acquisition of land, buildings and equipment.

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8080 Amortization of Financing Cost  
Amortization expense of long term financing cost such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

HOME OFFICE COSTS

8090 Home Office Costs/Capital Cost  
Capital expenses of a separate division or entity which owns, leases or manages more than one facility (home office). These costs must be related to capital cost as specified in the capital cost center, and are allocated to the facility in accordance with "CMS Publication 15-1," sections 2150 through 2150.3, "Home Office Costs" (REV. 11/05).

RENOVATIONS

8500 Depreciation/Amortization  
Depreciation and amortization expenses for renovations.

8570 Interest - Renovations  
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for renovation purposes.

8580 Amortization of Financing Cost - Renovations  
Amortization expense for cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc. incurred for renovations.

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**Intermediate care facility for the mentally retarded (ICF-MR):  
medicaid cost report.**

(A) The ICF-MR medicaid cost report must be filed in accordance with the requirements set forth in rules 5101:3-3-20 and 5101:3-3-71 of the Administrative Code. Appendix A of this rule is the cost report which shall be issued to ICF-MR providers at least sixty days before the due date of the cost report for each cost reporting period.

TN 06-010 Approval Date 05/17/07  
Supersedes

TN 03-017 Effective Date 07/01/06

**Instructions for completing the Ohio department of job and family services (ODJFS) calendar year  
medicaid cost report for intermediate care facilities for the mentally retarded (ICFs-MR)**

**GENERAL INSTRUCTIONS**

**OVERVIEW**

As a condition of participation in the Title XIX medicaid program, each ICF-MR shall file a cost report with ODJFS. The cost report, including its supplements and attachments, must be filed within ninety days after the end of the reporting period. The cost report shall cover a calendar year. However, if the provider participated in the medicaid program for less than twelve months during the calendar year, then the cost report shall cover the portion of a calendar year during which the ICF-MR participated in the medicaid program.

If a provider begins operations on or after October 2, the cost report shall be filed in accordance with rule 5101:3-3-20 of the Ohio Administrative Code (OAC).

For cost reporting purposes, ICFs-MR other than state-operated facilities shall use the Chart of Accounts for ICFs-MR as set forth in rule 5101:3-3-71 of the OAC, or relate its chart of accounts directly to the cost report.

**ELECTRONIC SUBMISSION OF THE MEDICAID COST REPORT**

In accordance with the OAC, all providers are required to use the electronic cost report submission process. Providers have the option of using an ODJFS sponsored computer software for electronic submission of the cost report or may select a vendor from an ODJFS approved list of vendors for an electronically submitted equivalent.

**FILING REQUIREMENTS**

The medicaid cost report must be filed with the department or postmarked on or before ninety days after the end of each facility's reporting period. Pursuant to the Ohio Revised Code (ORC), a provider whose cost report is filed or postmarked after this date is subject to a reduction of their per diem rate in the amount of two dollars (\$2.00) per resident day, adjusted for inflation.

A provider may request a fourteen-day extension of the cost report filing deadline. Such requests must be made in writing, include an explanation of the reason the extension is being requested, and must demonstrate good cause in order to be granted. Requests should be made to the Bureau of Long Term Care Facilities Reimbursement Section.

In the absence of a timely filed cost report, or request for filing extension, a provider will be notified by ODJFS of its failure to file a cost report and will be given thirty days to file the appropriate cost report and attachments. During this thirty day period, the late filing rate reduction described previously will be assessed. If a provider fails to submit a cost report within this time period, its medicaid provider agreement will be terminated according to section 5111.26 (A)(2) of the ORC.

**REASONABLE COST**

Please read all instructions carefully before completing the cost report.

Reasonable cost takes into account direct, indirect, capital and other protected costs of providers of services, including normal standby costs. Departmental regulations regarding reasonable and allowable costs are contained in Chapter 5101:3-3 of the OAC. In addition, the following provisions establish guidelines and procedures to be used in determining reasonable costs for services rendered by ICFs-MR:

- Ohio Revised Code (ORC) and uncodified state law;
- ODJFS-promulgated regulations (OAC) codified in accordance with state law;
- Principles of reimbursement for provider costs with related policies described in the Centers for Medicare and Medicaid Services (CMS) Publication 15-1 (REV. 11/05);
- Principles of reimbursement for provider costs with related policies described in the Code of Federal Regulations (CFR), Title 42, Part 413 (REV. 10/05).

**ROUTINE SERVICES**

The OAC lists covered services for all providers who serve ICF-MR residents. This rule delineates services reimbursed through the cost reporting mechanism of ICFs-MR, and the costs directly billed to medicaid by service providers other than ICFs-MR.

**ACCOUNTING BASIS**

Except for county-operated facilities which operate on a cash method of accounting, all providers are required to submit cost data on an accrual basis of accounting. County-operated facilities which utilize the cash method of accounting may submit cost data on a cash basis.

**OHIO MEDICAID COST REPORT FORMS**

The Ohio medicaid ICFs-MR cost report (JFS 02524 Rev. 02/2006) is designed to provide statistical data, financial data, and disclosure statements as required by federal and state rules. Exhibits to the cost report are part of the documents that may be required to file a complete cost report. Each exhibit to the cost report must be identified and cross-referenced to the appropriate schedule(s). Please refer to Attachment 3 for instruction on the use of exhibits.

**COST REPORT SCHEDULES**

The provider must complete the information requested on each cost report schedule. Except for the cost report schedules and attachments listed below, responses such as "Not Applicable," "N/A," "Same as Above," "Available upon request," or "Available at the time of Audit," will result in the cost report being deemed incomplete or inadequate. Pursuant to section 5111.26 (A)(2) of the ORC, an incomplete or an inadequate cost report is subject to a rate reduction of \$2.00 per resident per day, adjusted for inflation as well as proposed termination of the provider agreement.

**TABLE OF COST REPORT SCHEDULES**

<b><u>Cost Report Schedules</u></b>	<b><u>Title</u></b>	<b><u>Page Number</u></b>
Schedule A, Page 1	Identification and Statistical Data	Page 1
Schedule A, Page 2	Chain Home Office/Certification by Officer of Provider	Page 2
Schedule A-1	Summary of Inpatient Days	Page 3
Schedule A-2	Determination of Medicare Part B Costs to Offset	Page 4
Schedule A-3	Summary of Costs	Page 5
Schedule B-1	Other Protected Costs	Page 6
Schedule B-2	Direct Care Cost Center	Pages 7-8
Schedule C	Indirect Care Cost Center	Pages 9-11
Schedule C-1	Administrators' Compensation	Page 12
Schedule C-2	Owners'/Relatives' Compensation	Pages 13-14
Schedule C-3	Cost of Services From Related Parties	Pages 15-17
Schedule D	Capital Cost Center	Page 18
Schedule D-1	Analysis of Property, Plant and Equipment	Page 19
Schedule D-2	Capital Additions and/or Deletions	Page 20
Schedule E	Balance Sheet	Page 21
Schedule E-1	Return on Equity Capital of Proprietary Providers	Pages 22-23
Attachment 1	Revenue Trial Balance	Pages 24-26
Attachment 2	Adjustment to Trial Balance	Page 27
Attachment 3	Medicaid Cost Report Supplemental Information	Page 28
Attachment 4	Paid Non-Medicaid Leave Days	Page 29
Attachment 6	Wage and Hours Survey	Pages 30-32
Attachment 7	Addendum for Disputed Costs	Page 33

**COST REPORT INSTRUCTIONS**

The following cost report instructions are in the order of schedule completion sequence.

- All expenses are to be rounded to the nearest dollar.
- All dates should contain eight digits and be formatted as follows: Month-Day-Year (MM-DD-YYYY).
- All date fields are denoted as From/Through or Beginning/Ending.

Example: January 1, (20CY) should be recorded as 010120CY (zero, one, zero, one, 20CY).

<b><u>Sequence and Procedures for Completing Cost Report (JFS 02524 Rev. 9/2005)</u></b>	<b><u>Cost Report Page Number</u></b>
1. Schedule A, Page 1 of 2, Identification	1
2. Schedule A-1	3
3. Attachment 4	29
4. Schedule A, Page 1 of 2, statistical data line 1 through line 8	1
5. Attachment 1	24 - 26
6. Schedule A-2	4
7. Schedule B-1 (columns 1 through 3 )	6
8. Schedule B-2 (columns 1 through 3 )	7 - 8
9. Schedule C (columns 1 through 3 )	9 - 11
10. Schedule D-1	19
11. Schedule D-2	20
12. Schedule D (column 3 )	18
13. Attachment 2	27
14. Schedules B-1, B-2, C and D (columns 4 - 7 )	6 - 11, 18
15. Schedule C-1	12
16. Schedule C-2	13 - 14
17. Schedule C-3	15 - 17
18. Schedule E	21
19. Schedule E-1	22 - 23
20. Schedule A-3	5
21. Attachment 6	30 - 32
22. Attachment 7	33
23. Attachment 3	28
24. Schedule A, Page 2 of 2	2

1. Schedule A, Page 1 of 2 - Identification and Statistical Data

INTRODUCTION:

The various cost report types are explained below. Except for 4.1, annual cost report, all other cost report types must be accompanied with a cover letter explaining the reason for the filed cost report information. An explanation of the cost report types is as follows:

- |                               |                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 4.1 - Year End                | Cost reports by providers with continued medicaid participation having ending dates of December 31, pursuant to the OAC.                                                                                                                                                                                                          |
| 4.2 - New Facility            | For facilities new to the medical assistance program, where the actual cost of operations are reported for the first three (3) full calendar months, which includes the date of certification, pursuant to the OAC.                                                                                                               |
| 4.3 - Change Of<br>Operator   | For the new operator's three (3) month cost report resulting agreement from a change of provider agreement pursuant to the OAC, which reports the actual cost of operations for the first three (3) full calendar months of medicaid participation including the date of certification for the new operator, pursuant to the OAC. |
| 4.4 - Rate<br>Reconsideration | For cost reports filed pursuant to the OAC where a change (extreme circumstances or hardships) in the current fiscal year payment rate is requested.                                                                                                                                                                              |
| 4.5 - Final                   | For the final cost report of a provider who has experienced a change of provider agreement pursuant to the OAC.                                                                                                                                                                                                                   |
| 4.6 - Amended                 | For cost reports filed after the fiscal year rate setting, which corrects errors of the cost report used to establish the fiscal year rate, pursuant to the OAC.                                                                                                                                                                  |
| 4.7 - Capital Report          | For the three (3) month projected capital cost report filed, which includes cost report Schedules A, A-1, and all property schedules, by the operator of a new facility, or new operator resulting from a change of provider agreement, where an approved step up calculation for capital cost is requested.                      |

**Facility Identification**

**Provider Name (DBA)** - Enter the "doing business as" (DBA) name of the facility as it appears on the medicaid provider agreement.

**National Provider Identifier (NPI)** - Enter the NPI if available. The transition from existing health care provider identifiers to NPIs in standard transactions will occur over the next couple of years. Health care providers could begin applying for an NPI beginning on May 23, 2005. While the NPI must be used on standard transactions with health plans, other than small health plans, no later than May 23, 2007, health care providers should not begin using the NPI in standard transactions on or before the compliance dates until health plans have issued specific instructions on accepting the NPI. ODJFS will notify you when you can begin using NPIs in standard transactions. Applying for an NPI does not replace any enrollment or credentialing processes with medicaid.

**Medicaid Provider Number** - Enter the seven digit medicaid provider number as it appears on the medicaid provider agreement.

**Medicare Provider Number** - Enter the six digit medicare provider number furnished by the Ohio Department of Health (ODH) or the CMS. Medicare numbers are assigned to each facility regardless of the facility's medicare certification status. The medicare number also appears on the medicaid provider agreement.

**Complete Facility Address** - Enter the address of the facility. Include city and ZIP code where the facility is physically located.

**Federal ID Number**- Enter the Federal Tax Identification Number as it is reported to the United States Internal Revenue Service.

**ODH ID Number** - Enter the ODH 4-digit home number, also referred to by ODH as the "Fac ID" Number.

**County** - Enter the Ohio county in which the facility is physically located.

**Period Covered by the Cost Report**

This is a twelve-month period ending December thirty-first unless another period has been designated by the Department. New facilities, closed facilities, or exiting or entering operators as a result of a change of operator must indicate the time period of medicaid participation.

**Provider Legal Entity Identification**

Name and address of provider of services - Enter the legal business name for the provider of this facility as reported to the IRS for tax purposes and as it appears on the medicaid provider agreement, and furnish the address of this legal entity.

**Type of Control of Provider**

Check the category that describes the form of business, nonprofit entity or government organization under which the facility is operated, which corresponds for non-government organizations with the way the operator legal entity is registered with the Ohio Secretary of State's office. If item 1.4, 2.6 or 3.6 Other [specify] is checked, the provider must identify that specific type of control. Descriptions for the "For Profit" control types are furnished below.

**For Profit**

**Sole Proprietor** – Exclusively owned; Private; Owned by a private individual or corporation under a trademark or patent; Ownership – for profit. In a sole proprietorship the individual proprietor is subject to full liability (personal assets and business assets) resulting from business acts.

**Partnerships** – An association of two or more persons or entities that conducts a business for profit as co-owners. A partnership cannot exist beyond the lives of the partners. The partners are taxed as individuals and are personally liable for torts and contractual obligations. Active partners are subject to self-employment tax. Each partner is viewed as the other's agent and traditionally is jointly and severally liable for the tortuous acts of any one of the partners. A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in some fixed proportion in profits and losses.

**General Partnership** – A partnership in which each partner is liable for all partnership debts and obligations in full, regardless of the amount of the individual partner's capital contribution.

**Limited Partnership** – A partnership in which the business is managed by one or more general partners and is provided with capital by limited partners who do not participate in management but who share in profits and whose individual liability is limited to the amount of their respective capital contributions. A limited partnership is taxed like a partnership but has many of the liability protection aspects of a corporation. To form a limited partnership, a certificate of limited partnership must be executed and filed with the Secretary of State (Secretary of State prescribes the form required). The name of a limited partnership must include the words "Limited Partnership," "L.P.," "Limited," or "Ltd."

**Limited Liability Partnership** – a partnership formed under applicable state statute in which the partnership is liable as an entity for debts and obligations and the partners are not liable personally. This type of partnership must register with the Secretary of State as a limited liability partnership.

**Corporation** – An invisible, intangible, artificial creation of the law existing as a voluntary chartered association of individuals that has most of the rights and duties of natural persons but with perpetual existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest.

**Limited Liability Companies** – An unincorporated company formed under applicable state statute whose members cannot be held liable for the acts, debts, or obligations of the company and that may elect to be taxed as a partnership. A limited liability company may be formed in Ohio by any person without regard to residence, domicile or state or organization. The entity is formed when one or more persons of their authorized representatives signs and files articles of organization with the Secretary of State. The name of the limited liability company must include the words "limited liability company," "LLC," "L.L.C.," "Ltd.," "Ltd," or "Limited." A "person" includes any natural person, corporation, partnership, limited partnership, trust, estate, association, limited liability company, any custodian, nominee, trustee, executor, administrator, or other fiduciary.

**Business Trust** – A business trust is created by a trust agreement and can only be created for specific purposes: To hold, manage, administer, control, invest, reinvest, and operate property; to operate business activities; to operate professional activities; to engage-in any lawful act or activity for which business trusts may be formed per the ORC.

**Real Estate Investment Trust (REIT)** - means a trust created by an instrument, pursuant to common law or enabling legislation, under which any estate or interest in real property is held, managed, administered, controlled, invested, reinvested, or operated by a trustee or trustees for the benefit and profit of persons who are or may become the holders of transferable certificates of beneficial interest, issued pursuant to the provisions of the trust instrument, such transferability being either restricted or unrestricted, which trust intends to comply or has at any time complied or intended to comply with sections 856, 857, and 858 of the Internal Revenue Code of 1954, 68 A Stat. 3, 26 U.S.C. 1, as now or hereafter amended.

**Location of Entity, Organization or Incorporation**

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

**Domestic** refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

**Foreign** refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio.

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

### Non-Profit

**Non-Profit Corporation** - A "nonprofit corporation" is a domestic or foreign corporation organized otherwise than for pecuniary gain or profit. A non-profit corporation can be either a "mutual benefit corporation" or a "public benefit corporation." A "public benefit corporation" is a corporation that is recognized as exempt from federal income taxation under 501(c)(3) of the "Internal Revenue Service Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended, or is organized for a public or charitable purpose and, that upon dissolution, must distribute its assets to a public benefit corporation, the United State, a state or any political subdivision of a state, or a person that is recognized as exempt from federal income taxation under 501(c)(3) of the "Internal Revenue Code of 1986" as amended.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

**Domestic** refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

**Foreign** refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

**Non-Federal Government**

**State** – entity operated under the authority of the state.

**County** – entity operated under the authority of the county as a County Home, County Nursing Home, or District Home in accordance with the ORC.

**City** – entity operated under the authority of the city.

**City/County** – entity operated under the authority of the city & county.

**Care Setting**

Indicate the care setting of the facility, in accordance with licensure standards filed with ODH, when applicable. Please check all that apply.

**Definitions**

**Rehab Hospital Based** – serves an inpatient population of whom at least 75% require intensive rehabilitative services; has a preadmission screening procedure which determines whether the patient will benefit significantly from an intensive inpatient hospital program or assessment; and uses a coordinated multidisciplinary team approach in the rehabilitation of each inpatient. Inpatients using rehabilitative services usually have one or more of the following diagnoses: stroke, spinal cord injury, congenital deformity, major multiple trauma, femur fracture, brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders and burns.

**General/Acute Hospital Based** – means a hospital which primarily functions to furnish the array of diagnostic and therapeutic services needed to provide care for a variety of medical conditions, including diagnostic x-ray, clinical laboratory, and operating room services.

**Home for the Aging** – Per the ORC, means a home that provides services as a residential care facility and a nursing home, except that the home (nursing home) provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

**Continuing Care Retirement Center (CCRC)** – means a living setting which encompasses a continuum of care ranging from an apartment or lodging, meals, and maintenance services to total nursing home care. All services are provided on the premises of the continuing care retirement community and are provided based on the contract signed by the individual resident. The residents may or may not qualify for medicaid for nursing home care, based on the services covered by each resident's individually signed contract.

**Other Assisted Living/Nursing Home combination** – A facility that does not fit the description of a CCRC or a Home for the Aging, but has a nursing home as well as some other combination of assisted living or residential care facility services on the same campus.

**Religious Non-medical Health Care Institution (RNHCI)** - An institution in which health care is furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets for care and healing, as set forth in the Code of Federal Regulations (CFR), Title 42, Part 403 (REV. 10/05).

**Free Standing** – A facility that stands independent of attachment or support.

**Combined with NF, other recognized Medicaid ICF-MR and/or Medicaid Outlier Unit** -- A distinct part of a facility that is in the same building and/or shares the same license with a certified NF, or is in same building as a recognized separate provider of medicaid, such as a provider of outlier services (e.g., for pediatric residents or residents with traumatic brain injury), or for the outlier unit, is housed with a NF providing non-outlier services. [Note: A provider of ICF-MR outlier services holds an Ohio medicaid provider agreement addendum authorizing the provision of outlier services to a special population (e.g., pediatric subacute).]

**Name and Address of Owner of Real Estate** - Enter the name and address of the owner of the real estate where the facility is located. If the provider of services is the identical legal entity that owns the real estate, re-enter the provider's legal entity identification here.

**2. Schedule A-1, Summary of Inpatient Days**

Column 1: Record the number of ODH-certified beds, by month. If the number of beds certified by ODH changed during the middle of any given month, then calculate a weighted average for that particular month rounded to the nearest whole number.

For example:

March 1, 20CY      100 certified beds

March 16, 20CY    120 certified beds

Calculation : (15 days x 100 beds) + (16 days x 120 beds)  
 divided by 31 days in month of March = 110.3226

Average medicaid certified beds for March 20CY = 110

Column 2: Record the number of authorized skilled, intermediate, mental retardation and pending medicaid patient days, by month.

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Column 3

and 4: Record the total monthly reimbursable leave days for medicaid residents [see OAC - coverage of medically necessary days and limited absences]. Report each necessary day and limited absence as 100% of an inpatient day.

For Example:

Column 3	Hospital Leave Days	60	(60 days x 100%)
Column 4	Therapeutic Leave Days	40	(40 days x 100%)

Column 5: Total of columns 2, 3, and 4. Carry the total on line 13, column 5 forward to Schedule A, line 7.

Column 6,

7 and 8: Record the number of inpatient days for non-medicaid eligible residents, by month. Leave days should not be included in these columns but should be reported on Attachment 4.

Column 9: Record the number of inpatient days for all residents, by month. This column is the sum of columns 5 through 8.

The day of admission, but not the day of discharge, is an inpatient day. When a resident is admitted and discharged on the same day, this is counted as one inpatient day. Inpatient days include those leave days that are reimbursable under the Ohio medicaid program. Private leave days are not included as inpatient days. Carry the total on line 13, column 9 forward to Schedule A, line 4, column 1.

Pursuant to the OAC, reimbursement may be made to reserve a bed for not more than thirty days in any calendar year for any combination of hospital stays or visits with friends or relatives or participation in therapeutic programs.

For ICFs-MR, reimbursement for medically necessary leave days is one hundred per cent (100%) of the facility's per diem rate.

**3. Attachment 4, Paid Non-Medicaid Leave Days**

Record the monthly non-medical leave days paid for by payers other than ODJFS.

**4. Schedule A, Page 1 of 2, Statistical Data**

Lines 1 and 2: Licensed Beds:

Enter the total number of beds licensed by ODH in column 2. Enter the total number of beds licensed by ODH and certified by medicaid in column 1. Temporary changes because of alterations, painting, etc. do not effect bed capacity.

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Line 3: Total Bed Days:

For column 1, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH and certified by medicaid during the reporting period. Take into account increases or decreases in the number of beds licensed and certified and the number of days elapsed since the increase or decrease in licensed and certified beds.

For column 2, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH during the reporting period. Take into account increases or decreases in the number of beds licensed and the number of days elapsed since the increases or decreases.

Line 4: Total Inpatient Days:

For column 1, obtain the answer from Schedule A-1, column 9, line 13. For column 2, enter the total number of inpatient days for the facility for all ODH licensed beds.

Line 5: Percentage of Occupancy:

This amount is the proportion of total inpatient/resident days to total bed days during the reporting period. Obtain the answer by dividing line 4 by line 3.

Line 6.1: Indirect Care Allowable Days:

For computing indirect care costs, ODJFS will not recognize an occupancy rate of less than 85%. If percentage of occupancy is 85% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 85%, enter 85% of the number of bed days stated on line 3 (See the OAC). For providers on the medicaid program less than 12 months, also consult the OAC.

Lines 6.2: Capital Allowable Days:

For computing property ownership costs, ODJFS will not recognize an occupancy rate of less than 95%. If percentage of occupancy is 95% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 95%, enter 95% of the number of bed days stated on line 3 (See the OAC). For providers on the medicaid program less than 12 months, also consult the OAC.

\*\* Number of beds involved in the change refers only to those beds which were added, replaced, or removed.

**5. Attachment 1 - Revenue Trial Balance**

Column 2: Enter total revenue for each line item.

Column 3: Enter any adjustments. Detail the adjustment(s) on your exhibit and submit with the cost report.

**6. Schedule A-2, Determination of Medicare Part B Costs to Offset:**

This schedule is designed to determine the amount of Medicare Part B revenue to offset on the cost report by cost center to comply with the OAC.

**Section A: Revenues**

Lines 1a, 2a, and 3a List gross charges for all residents by payer type. Gross charges must be reported from a uniform charge structure that is applicable to all residents. Revenue reported under chart of account numbers 5080 (medical supplies-routine), 5100 (medical minor equipment-routine), and 5110 (enteral nutritional therapy) must be distributed among all non-medicare categories.

Lines 1b, 2b, and 3b: For columns 2 through 7, these lines represent the percentages of the individual revenue reported by payer type divided by the total revenue reported in column 8. Report the percentages by payer type and limit the precision to four places to the right of the decimal. The total of all percentages must equal 100%.

Line 4: Total all revenue reported on lines 1a, 2a, and 3a.

**Section B: Costs**

Line 5: Enter the ratio of Medicare Part B charges where the primary payer is medicaid from column 2 line 1b, 2b, and 3b. These ratios must be entered in the corresponding column, e.g., medical supplies percentage from column 2 line 1b must be entered on line 5, column 2 medical supplies.

Line 6: Enter the corresponding costs from Schedules B-1 and C, column 3 in the appropriate column.

Line 7: Multiply line 5 times line 6. The result is the costs to offset on the appropriate line on Schedule B-2 and C, column 4.

**Section C: Indirect Cost-Offset**

NOTE: Failure to complete Schedule A-2 will result in all Medicare Part B revenue being offset against other protected expenses on Schedule B-1, line 1.

**7. Schedule B-1, Other Protected Costs (Columns 1-4)**

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "other" category and provide supporting documentation as exhibits with cross references to the applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll. Also report any appropriate non-wage expenses, including contract services and supplies.

Column 4: Report any increases or decreases of each line item. Any entries in this column which are not from Attachment 2 should be fully explained in accordance with the instructions on Attachment 3.

**8. Schedule B-2, Direct Care Cost Center, (Columns 1-3)**

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to "Other Direct Care" line 23 and specify the detail in the spaces provided at the bottom of Schedule B-2, page 1 of 2. Provide supporting documentation as exhibits with cross references to applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll. Also, report any appropriate non-wage expenses, including contract services and supplies.

Column 3: Total of columns 1 and 2.

**9. Schedule C, Indirect Care Cost Center, (Columns 1-3)**

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "Other Indirect Care" line 47 and specify the detail in the spaces provided at the bottom of Schedule C, page 2 of 3. Provide supporting documentation as exhibits with cross references to applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report costs incurred for services performed by contracted personnel employed by the facility to do a service that would otherwise be performed by personnel on the facility's payroll. Also, report any appropriate non-wage expenses, including contract services and supplies.

Column 3: Total of columns 1 and 2.

**10. Schedule D-1, Analysis of Property, Plant and Equipment**

Complete per instructions on the form. This schedule should tie to Schedule E, (balance per books) property, plant, and equipment section.

**11. Schedule D-2, Capital Additions and/or Deletions**

Complete per instructions on the form. Completion of this schedule is optional if the detailed depreciation schedule is submitted which includes all criteria noted on Schedule D-2 except for columns 8 and 11. Columns 12 and 13 are mandatory only in the event of an asset deletion.

**12. Schedule D (Column 3), Capital Cost Center**

Complete per instructions on the form.

**13. Attachment 2, Adjustment to Trial Balance**

Columns 2 and 3, lines 1 through 20:

Enter the appropriate adjustments as necessary to comply with CMS 15-1, federal regulations, state laws, and Ohio medicaid program regulations. Items included on Attachment 2 must have attached supportive detail. Cost adjustments for related party transactions must offset the appropriate expense account in column 4 of Schedules B-1, B-2, C and D.

Column 5, lines 1 through 20:

In column 5, cross-reference adjustments to the appropriate expense account number. Carry the adjustment in column 4 to the appropriate expense account on Schedules B-1, B-2, C and D, column 4.

Note: All adjustments to expense accounts should be made to the appropriate line of Schedules B-1, B-2, C and D and the appropriate expense account number entered on Attachment 2, column 5.

Column 6, lines 1-20, line reference from Attachment 1 (if applicable).

After completing Attachment 2 and entering adjustments to expense Schedules B-1, B-2, C and D, column 4, the adjusted total expenses (Schedules B-1, B-2, C and D, column 5) can be computed.

**14. Schedules B-1, B-2, C and D (Columns 4-7)**

Column 4: Report any increases or decreases of each line item. Any entries in this column which are not from Attachment 2 should be fully explained in accordance with the instructions on Attachment 3.

If no allocations are used, columns 6 and 7 need not be completed. If allocation is used, limit the precision to four places to the right of the decimal.

**15. Schedule C-1, Administrators Compensation**

A separate schedule must be completed for each person(s) claiming reimbursement as an administrator in this facility.

**Section A:**

Line 2: Work Experience

For this administrator, report the number of years of work experience in the health care field. Ten years experience is the maximum allowance. Thus, for this category, if the administrator has ten or more years experience in the health care field, then record ten years in this box.

Line 3: Formal Education

For this administrator, report the number of years of formal education beyond high school. Six years formal education is the maximum allowance for this category. Thus, if the administrator has six or more years formal education, then record six years in this box.

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Line 3.1: Baccalaureate Degree

For this administrator, record yes if the administrator has obtained a baccalaureate degree. If the administrator has not obtained a baccalaureate degree, then record no.

Line 4: Other Duties:

Record the total number of other duties not normally performed by this administrator. This administrator may claim up to four additional duties. If this administrator performed four or more extra duties, then report the maximum of four.

Include the following *other duties* in your count: accounting, maintenance, and housekeeping. If the administrator performed any other duties, please complete the "Other, specify" lines. For example, if the administrator performed laundry duties, then record as follows: Other, specify laundry.

Do not include any of the direct care duties listed below. If the administrator performed any of the twelve duties listed below then go to Schedule C-2. Complete Page 1 of Schedule C-2. If the administrator is an owner or relative of the owner, then complete Page 2 also.

- (a) Medical director
- (b) Director of nursing
- (c) Activities director
- (d) Registered nurse (RN)
- (e) Licensed practical nurse (LPN)
- (f) Psychologist
- (g) Respiratory therapist
- (h) Qualified mental retardation professional (QMRP)
- (i) Licensed social worker/counselor
- (j) Chaplain
- (k) Charge nurse; registered
- (l) Charge nurse; licensed practical

Line 5: Geographic Location:

Add 6% if the facility is in one of the following counties: Cuyahoga, Hamilton, Butler, Stark, Franklin, Lucas, Montgomery or Summit.

NOTE: The eight counties listed above reflect those counties projected to have the largest populations. This information is subject to change once the calendar year data becomes available.

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Line 6: Ownership Points:

Add ten points if the administrator is also an owner.

Line 7: Total lines 1 through 6.

Line 8: Line 7 is not to exceed 150%.

**Section B:**

For each administrator complete the following:

Beginning and ending dates of employment during the 20CY reporting period should be confined to periods of employment in 20CY only. For example, if the administrator was employed by the provider from March 1, 20CY through March 31, 20CY, then for the 20CY reporting period the record of employment dates is as follows: 03/01/20CY - 03/31/20CY.

Hours and percentage of time worked weekly on site at the facility.

Account number 7200 or account number 7310, as appropriate. All administrators compensated through the home office use account 7310. All other administrators use account 7200.

Amount of compensation: Except for county facilities which operate on a cash basis, list all compensation actually accrued to employees who perform duties as the administrator. County facilities which operate on a cash basis should list all compensation actually paid to employees who perform duties as the administrator.

If the administrator is an owner or relative of an owner, then complete Schedule C-2, Page 2 of 2. Do not complete Schedule C-2, Page 2 of 2 for a non-owner/administrator. Report the cost of all indirect care-related duties performed by administrator on Schedule C, line 26, account number 7200 or Schedule C, line 48, account number 7310, whichever is applicable.

The applicable Direct Care duties are:

- |                                     |                                                       |
|-------------------------------------|-------------------------------------------------------|
| (a) Medical Director;               | (h) Qualified Mental Retardation Professional (QMRP); |
| (b) Director of Nursing;            | (i) Licensed Social Worker/Counselor;                 |
| (c) Activities Director;            | (j) Chaplin;                                          |
| (d) Registered Nurse (RN);          | (k) Charge Nurse; Registered; and,                    |
| (e) Licensed Practical Nurse (LPN); | (l) Charge Nurse; Licensed Practical.                 |
| (f) Psychologist;                   |                                                       |
| (g) Respiratory Therapist;          |                                                       |

Example: An owner/administrator (or relative of owner) earned \$65,000 compensation performing duties as follows:

RN \$15,000; Administrator \$45,000; Laundry \$5,000; Total = \$65,000

Compensation may be reported as follows:

Schedule C-1 = \$50,000 - Administrator plus laundry compensation

Schedule B-2 = \$15,000 - RN compensation

Please note the reporting procedures are the same regardless of whether the administrator is an owner/administrator, or a relative of the owner.

Non-owner administrators will report their wages on Schedule C-1 (administrator and general wages) and, if it applies, Schedule B-2 (direct care wages, as stipulated in the direct care duties list above). Wages for non-owner/administrators are never reported on Schedule C-2.

## 16. Schedule C-2

### Page 1 of 2:

List all owners and/or relatives who received compensation from this provider. Also, complete the schedule if any administrator wages are reported on Schedule B-2 for the direct care duties listed on page 17 of the instructions. This applies regardless of whether the administrator is a non-owner/administrator, an owner/administrator, or a relative of the owner.

Specify the name of person(s) claiming compensation, position number (see below), relationship to owner(s), years of experience in this field, dates of employment in this reporting period, number of hours worked in facility during the week, as well as the corresponding percentage of time worked at this facility, account number, and amount claimed for each person listed on the cost report.

For purposes of completing Schedule C-2, the following relationships are considered related to the owner:

- (1) Husband and wife;
- (2) Natural parent, child, and sibling;
- (3) Adopted child and adoptive parent;
- (4) Stepparent, stepchild, stepbrother, stepsister;
- (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, and brother-in-law;
- (6) Grandparent and grandchild; and,
- (7) Foster parent, foster child, foster brother, or foster sister.

**Page 2 of 2:**

Except for the non-owner administrators, for each individual identified above, list all the compensation received from other facilities participating in the medicaid program (in Ohio and other states). Also, list any individual owning a 5% or more interest in this provider. Compensation claimed must be for necessary services and related to resident care. Services rendered and compensation claimed must be reasonable based upon the time spent in performing the duty, and reasonable for the duty being performed.

If Schedule C-2, Page 1 is completed for a non-owner administrator, then do not complete this page for the non-owner administrator. All other owners, relatives of owners, or owner/administrators identified on Page 1 must also be reported on Page 2 of Schedule C-2.

**Position Numbers for Corporate Officers**

Select the four-digit position number that appropriately identifies the job duty of the corporate officer.

Example: Where there is a corporate president of a 50-bed facility, the four digit position number is: CP01 (C, P, zero, one).

**1. Corporate President Series (CP)**

- CP01 - Corporate President 1 (1 - 99 beds)
- CP02 - Corporate President 2 (100 - 199)
- CP03 - Corporate President 3 (200 - 299)
- CP04 - Corporate President 4 (300 - 599)
- CP05 - Corporate President 5 (600 - 1199)
- CP06 - Corporate President 6 (1200 +)

**2. Corporate Vice - President Series (CV)**

- CV01 - Corporate Vice-President 1 (1 - 99 beds)
- CV02 - Corporate Vice-President 2 (100 - 199)
- CV03 - Corporate Vice-President 3 (200 - 299)
- CV04 - Corporate Vice-President 4 (300 - 599)
- CV05 - Corporate Vice-President 5 (600 - 1199)
- CV06 - Corporate Vice-President 6 (1200 +)

**3. Corporate Treasurer Series (CT)**

- CT01 - Corporate Treasurer 1 (1 - 99 beds)
- CT02 - Corporate Treasurer 2 (100 - 199)
- CT03 - Corporate Treasurer 3 (200 - 299)
- CT04 - Corporate Treasurer 4 (300 - 599)
- CT05 - Corporate Treasurer 5 (600 - 1199)
- CT06 - Corporate Treasurer 6 (1200 +)

**4. Board Secretary Series (BS)**

- BS01 - Corporate Board Secretary 1 (1 - 99 beds)
- BS02 - Corporate Board Secretary 2 (100 - 199)
- BS03 - Corporate Board Secretary 3 (200 - 299)
- BS04 - Corporate Board Secretary 4 (300 - 599)
- BS05 - Corporate Board Secretary 5 (600 - 1199)
- BS06 - Corporate Board Secretary 6 (1200 +)

**Position Number for Owners/Relatives of Owner**

Select the five-digit position number, which appropriately identifies the job duty of the owner and/or relative of the owner. Please note that **WH** references the Wage and Hour Survey - Attachment 6 of the cost report.

Example: Where the owner served as medical director of the facility, the five-digit position number is: WH002 (W, H, zero, zero, two).

<u>WH Code</u>	<u>Title</u>	<u>Account</u>	<u>Schedule / Line</u>
WH001	Water and Sewage	6030	Schedule B-1, line 9
WH063	EAP Administrator - Other Protected	6057	Schedule B-1, line 22
WH064	Self Funded Programs Admn. - Other Protected	6058	Schedule B-1, line 23
WH065	Staff Development - Other Protected	6059	Schedule B-1, line 24
WH002	Medical Director	6100	Schedule B-2, line 1
WH003	Director of Nursing	6105	Schedule B-2, line 2
WH004	RN Charge Nurse	6110	Schedule B-2, line 3
WH005	LPN Charge Nurse	6115	Schedule B-2, line 4
WH006	Registered Nurse	6120	Schedule B-2, line 5
WH007	Licensed Practical Nurse	6125	Schedule B-2, line 6
WH008	Nurse Aides	6130	Schedule B-2, line 7
WH009	Activity Director	6135	Schedule B-2, line 8
WH010	Activity Staff	6140	Schedule B-2, line 9

<u>WH Code</u>	<u>Title</u>	<u>Account</u>	<u>Schedule / Line</u>
WH012	Program Specialist	6150	Schedule B-2, line 10
WH013	Program Director	6155	Schedule B-2, line 11
WH015	Habilitation Supervisor	6165	Schedule B-2, line 12
WH016	Habilitation Staff	6170	Schedule B-2, line 13
WH017	Psychologist	6175	Schedule B-2, line 14
WH018	Psychology Assistant	6180	Schedule B-2, line 15
WH019	Respiratory Therapist	6185	Schedule B-2, line 16
WH020	Social Work/Counseling	6190	Schedule B-2, line 17
WH021	Social Services/Pastoral Care	6195	Schedule B-2, line 18
WH022	Qualified Mental Retardation Professional (QMRP)	6200	Schedule B-2, line 19
WH023	Quality Assurance	6205	Schedule B-2, line 20
WH024	Other Direct Care Salaries: Specify	6220	Schedule B-2, line 23
WH025	Home Office Costs/Direct Care: Salary	6230	Schedule B-2, line 24
WH026	DO NOT USE THIS POSITION CODE		
WH030	Physical Therapist	6600	Schedule B-2, line 30
WH031	Physical Therapy Assistant	6605	Schedule B-2, line 31
WH032	Occupational Therapist	6610	Schedule B-2, line 32
WH033	Occupational Therapy Assistant	6615	Schedule B-2, line 33
WH034	Speech Therapist	6620	Schedule B-2, line 34
WH035	Audiologist	6630	Schedule B-2, line 35
WH036	EAP Administrator-Direct Care	6535	Schedule B-2, line 40
WH037	Self-Funded Programs Administrator: Direct Care	6540	Schedule B-2, line 41
WH038	Staff Development-Direct Care	6550	Schedule B-2, line 42
WH039	Dietitian	7000	Schedule C, line 1
WH040	Food Service Supervisor	7005	Schedule C, line 2
WH041	Dietary Personnel	7015	Schedule C, line 3
WH042	EAP Administrator - Dietary	7075	Schedule C, line 15
WH043	Self-Funded Programs Administrator: Dietary	7080	Schedule C, line 16
WH044	Staff Development - Dietary	7090	Schedule C, line 17
WH045	Medical/Habilitation Records	7105	Schedule C, line 20
WH046	Pharmaceutical Consultant	7110	Schedule C, line 21
WH047	DO NOT USE THIS POSITION CODE		
WH048	Other Administrative Personnel	7210	Schedule C, line 27
WH049	Security Services (Salary Only)	7230	Schedule C, line 31
WH050	Laundry/Housekeeping Supervisor	7240	Schedule C, line 34
WH051	Housekeeping	7245	Schedule C, line 35
WH052	Laundry and Linen	7250	Schedule C, line 36
WH053	Accounting	7265	Schedule C, line 39
WH054	Data Services (Salary Only)	7285	Schedule C, line 43
WH055	Other Indirect Care - Specify: (Salary)	7305	Schedule C, line 47
WH056	Home Office Costs/Indirect Care (Salary)	7310	Schedule C, line 48

<u>WH Code</u>	<u>Title</u>	<u>Account</u>	<u>Schedule / Line</u>
WH057	DO NOT USE THIS POSITION CODE		
WH058	Plant Operations/Maintenance Supervisor	7320	Schedule C, line 50
WH059	Plant Operations and Maintenance	7330	Schedule C, line 51
WH060	EAP Administrator - Indirect Care	7525	Schedule C, line 59
WH061	Self-Funded Programs Administrator - Indirect Care	7530	Schedule C, line 60
WH062	Staff Development - Indirect Care	7535	Schedule C, line 61

**17. Schedule C-3, Cost of Services from Related Parties**

Complete per instructions on the form.

**Related Party** – means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

- (1) An individual who is a relative of an owner is a related party.
  - (a) "Relative of owner" means an individual who is related to an owner of a facility by one of the following relationships:
    - (1) Spouse;
    - (2) Natural parent, child, or sibling;
    - (3) Adopted parent, child, or sibling;
    - (4) Stepparent, stepchild, stepbrother, or stepsister;
    - (5) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law;
    - (6) Grandparent or grandchild;
    - (7) Foster caregiver, foster child, foster brother, or foster sister.
- (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
- (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

**Partnerships** – An association of two or more persons or entities that conduct a business for profit as co-owners, a partnership cannot exist beyond the lives of the partners. The partners are taxed as individuals and are personally liable for torts and contractual obligations. Active partners are subject to self-employment tax. Each partner is viewed as the other's agent and traditionally is jointly and severally liable for the tortuous acts of any one of the partners. A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in some fixed proportion in profits and losses.

**Corporations** – An invisible, intangible, artificial creation of the law existing as a voluntary chartered association of individuals that has most of the rights and duties of natural persons but with perpetual existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest. In the ORC, unless a corporation is specified as non-profit, it is assumed to be for-profit.

**Limited Liability Companies** – An unincorporated company formed under applicable state statute whose members cannot be held liable for the acts, debts, or obligations of the company and that may elect to be taxed as a partnership. A limited liability company may be formed in Ohio by any person without regard to residence, domicile or state or organization. The entity is formed when one or more persons of their authorized representatives signs and files articles of organization with the Secretary of State. The name of the limited liability company must include the words "limited liability company," "LLC," "L.L.C.," "Ltd.," "Ltd," or "Limited." A "person" includes any natural person, corporation, partnership, limited partnership, trust, estate, association, limited liability company, any custodian, nominee, trustee, executor, administrator, or other fiduciary.

**18. Schedule E, Balance Sheet**

Enter balances recorded in the facility's books at the beginning and at the end of the reporting period in the appropriate columns. Where the facility is a distinct part of a NF or ICF-MR, enter total amounts applicable only to the distinct part.

**19. Schedule E-1, Return on Equity Capital of Proprietary Providers**

Schedule E-1 is provided for computing reimbursable equity, the average equity capital amount, and the amount of return which is included in allowable costs.

Page 1 of 2

Lines 1 through 21 - calculate equity reimbursable under medicaid regulations.

Note: Lines 8 through 21 - Must specifically identify any amounts entered. An example of amounts that may be included on these lines is intercompany accounts.

Page 2 of 2

Lines 23 through 34:

- Column 2: Enter the equity capital as of the beginning of the reporting period, as computed on Schedule E-1, Page 1 of 2, line 22, column 1. This amount will be the same for all months during the period.
- Column 3: List, by month, capital investments made during the period. Capital investments include cash and other property contributed by owners and proceeds from the issuance of corporate stock. Do not include loans from owners. The amount entered on the appropriate line in column 3 is carried forward to subsequent months in the period, and is increased by additional contributions in the month(s) in which such contributions are made.
- Column 4: Enter net gain or loss from the disposition of assets. This column indicates the cumulative amount for the period.
- Column 5: Enter amounts withdrawn by owners or disbursed for the personal benefit of owners as well as the amounts paid as dividends to corporate stockholders. This column indicates the cumulative amount for the period, e.g., if withdrawals occur at the rate of \$600 per month, the first month of the period will show \$600, the second month \$1200, etc. However, if withdrawals are made and are reflected in the profit or loss for the period, e.g., salaries, the withdrawals should not be entered in this column.
- Column 6: Enter other changes in equity capital such as loans from owners (increases) and repayments of same (decreases). Unrestricted donations and contributions are also entered in this column (refer to CMS Publication 15-1, section 1210(A) (REV. 11/05)). Beginning with the first month in which a transaction occurs, the applicable amount is carried forward to subsequent months, and is increased by additional loans or decreased by repayment of loans.
- Column 7: Equity capital increases or decreases as income is earned or as losses are incurred by the provider during the reporting period. The net amount of change in equity capital, from this category of transactions, is determined by analyzing the difference between equity capital at the beginning of the period and equity capital at the end of the period. From this net increase or decrease in equity capital are subtracted the amounts included under the other categories of changes on Schedule E-1, columns 3 through 6. The remainder represents the increase or decrease due to operations; however, any amount for a return on equity capital included in the interim payments is further subtracted from this remainder. The increase or decrease due to operations is considered as earned uniformly during each month of the reporting period and affects equity capital cumulatively. For example, if the net increase due to profits in operations for 12 months is \$24,000, \$2,000 would be shown in the first month, \$4,000 in the second month, etc.

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**Appendix A**

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Column 8: Add columns 2 through 7. If the result is a negative amount, enter zero. Add the equity capital reported in column 8, etc. and indicate the total on line 35. The total on line 35 shall include only positive monthly balances.

Line 36 - Return on Equity:

Column 3: The rate of return used is an estimate based on the Commerce Clearing House Table of Interest Rates, and will be revised upon issuance of the appropriate update of the above publication. This is only an estimated rate of return and as such the resulting per diem should be used for budgeting purposes only.

**20. Schedule A-3, Summary of Costs**

Column 5: Calculate per diems for each cost category. This cost per diem is subject to change and does not reflect the payment to be made by medicaid.

**21. Attachment 6, Wage and Hour Survey**

Complete Attachment 6 per instructions to provide necessary information on the wage and hour supplement. There must be corresponding hours listed if wages are indicated.

Note: This schedule is utilized to calculate the statewide average annual compensation cost limit for owners and relatives of owners. Wages are to include wages for sick pay, vacation pay, and other paid time off as well as any other compensation paid to the employee. Please do not include contract wages or negative wages on this form. Except as noted below, the amounts reported in column (C) must agree to the corresponding account numbers on Schedule B-1, B-2, and C, column 1.

In circumstances involving related party transactions, or adjustments due to home office wages, the amounts reported in column (C) may not agree to the corresponding account numbers on Schedule B-1, B-2, and C, column 1. If the amounts reported do not agree, please explain the reason for the difference on Attachment 3, Exhibit 5 [or greater (i.e. Exhibit 6, Exhibit 7, etc.)].

**22. Attachment 7, Addendum for Disputed Cost**

This Attachment is for the reporting of costs as specified in section 5111.26 of the ORC that the provider believes should be classified differently than as reported on the cost report. Enter in the "Reclassification From" column the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3. Enter in the "Reclassification To" column the schedule, line number and reason you believe these costs should be reclassified.

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Appendix A

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23. **Attachment 3, Supplemental Information**

Attach requested documentation as instructed.

24. **Schedule A, Page 2 of 2, Certification by Officer of Provider**

Chain organizations are generally defined as multiple providers owned, leased, or through any other device, controlled by a single organization. For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by for profit /proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

The controlling organization is known as the chain "home office." Typically, the chain "home office:"

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills, and
- Maintains and centrally controls individual provider cost reports and fiscal records.
- In addition, a major portion of the medicare audit for each provider in the chain can be performed centrally at the chain "home office."

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office.

- A. **Check Box** – If this section does not apply to this provider, check the box provided and skip to the certification section.
- B. **Chain Home Office Information** – If there has been a change in the home office information since the previous cost reporting period, check "Change," and provide the effective date of the change.

Complete the appropriate fields in this section:

- Furnish the legal business name and tax identification number of the chain home office as reported to the IRS.
- Furnish the street address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.

- C. Provider's Affiliation to the Chain Home Office** – If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office since the last cost reporting period, check "Change," and provide the effective date of the change.

Check all that apply to indicate how this provider is affiliated with the home office.

All cost reports submitted by the provider must contain a completed certification signed by an administrator, owner, or responsible officer. The original signature must be notarized.

If the cost report preparer is a company, complete the "Report Prepared by (Company)" line only. If the cost report is completed by an individual, complete the "Report Prepared by (Individual)" line only.

Ohio Department of Job and Family Services  
MEDICAID ICF-MR COST REPORT

Type of Cost Report Filing pursuant to Ohio Administrative Code (Please check one of the following):			
<input type="checkbox"/> 4.1 Year-End	<input type="checkbox"/> 4.3 Change of Operator	<input type="checkbox"/> 4.5 Final	<input type="checkbox"/> 4.7 Capital
<input type="checkbox"/> 4.2 New Facility	<input type="checkbox"/> 4.4 Rate Reconsideration	<input type="checkbox"/> 4.6 Amended	

**INSTRUCTIONS:** This cost report must be received or postmarked pursuant to Ohio Administrative Code except for state operated ICFs-MR. Failure to file timely will result in reduction of the current prospective rate by two dollars (\$2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with Ohio Revised Code. Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit to Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414.

Provider Name (DBA)	National Provider Identifier	Medicaid Provider Number	Medicare Provider Number ## - ####
<b>Complete Facility Address:</b>		Federal Tax ID Number	Period Covered by Cost Report
Address (1)		ODH ID Number	From:
Address (2)		County	Through:
City State of Ohio			
Zip Code			
<b>TYPE OF CONTROL OF PROVIDER (please check one of the following.)</b>		<b>PROVIDER LEGAL ENTITY IDENTIFICATION</b>	
<b>For Profit</b>		Name of Legal Entity	
<input type="checkbox"/> Sole Proprietorship (1.1)		Address (1)	
<input type="checkbox"/> Partnership (1.2)		Address (2)	
<input type="checkbox"/> 1. General		City State	
<input type="checkbox"/> 2. Limited		Zip Code	
<input type="checkbox"/> 3. Limited Liability Partnership			
<input type="checkbox"/> Corporation (1.3)		<b>NAME AND ADDRESS OF OWNER OF REAL ESTATE</b>	
<input type="checkbox"/> Limited Liability Company (1.5)		Name	
<input type="checkbox"/> Business Trust (1.6)		Address (1)	
<input type="checkbox"/> Real Estate Investment Trust (REIT) (1.7)		Address (2)	
<input type="checkbox"/> Other : Specify Control: _____ (1.4)		City State	
		Zip Code	
<b>Location of Entity, Organization, or Incorporation:</b>		<b>CARE SETTING</b>	
If facility has a For Profit type of control, check one below:		Check all that apply:	
<input type="checkbox"/> Domestic (1.8)		<input type="checkbox"/> a. Rehab Hospital Based	
<input type="checkbox"/> Foreign (1.9) Location: _____		<input type="checkbox"/> b. General/Acute Hospital Based	
		<input type="checkbox"/> c. Home for the Aging	
		<input type="checkbox"/> d. Continuing Care Retirement Center (CCRC)	
		<input type="checkbox"/> e. Other Assisted Living/Nursing Home Combination	
		<input type="checkbox"/> f. Religious Non-Medical Health Care Institution	
		<input type="checkbox"/> g. Free Standing	
		<input type="checkbox"/> h. Combined with NF and/or Outlier Unit	
		<input type="checkbox"/> i. Other: Specify: _____	
<b>Non-Profit</b>			
<input type="checkbox"/> Domestic Non Profit Corporation (2.4)			
<input type="checkbox"/> Foreign Non Profit Corporation: Location: _____ (2.5)			
<input type="checkbox"/> Other (non defined "non profit" entity): Specify: _____ (2.6)			
<b>Non-Federal Government</b>			
<input type="checkbox"/> State (3.1)			
<input type="checkbox"/> County (3.2)			
<input type="checkbox"/> City (3.3)			
<input type="checkbox"/> City - County (3.4)			
<input type="checkbox"/> County - MR/DD Board (3.5)			
<input type="checkbox"/> Other: Specify Control: _____ (3.6)			

ALL PATIENTS

1. Licensed beds at beginning of period
- \*\* 2. Licensed beds at end of period
3. Total bed days available
4. Total inpatient days
5. Percentage of occupancy (line 4 divided by line 3 X 100)
- 6.1 Indirect allowable days (greater of line 4 or .85 X line 3)
- 6.2 Capital allowable days (greater of line 4 or .95 X line 3)

Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)

OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS

7. Total patient days (from Schedule A-1, line 13, column 5)
8. Utilization Rate (line 7 divided by line 4, col. 1 X 100)

\*\*IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE \_\_\_\_\_ AND NUMBER OF BEDS INVOLVED IN CHANGE \_\_\_\_\_

\*\*IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE \_\_\_\_\_ AND NUMBER OF BEDS INVOLVED IN CHANGE \_\_\_\_\_

\*\*IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE \_\_\_\_\_ AND NUMBER OF BEDS INVOLVED IN CHANGE \_\_\_\_\_

CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
---------------	--------------------------	---------------------------	----------

CHAIN HOME OFFICE INFORMATION			
This section is to be completed with information about the "HOME OFFICE" for those providers that are members of, or are joining, a chain organization.			
A. If this section does not apply check here _____			
B. Chain Home Office Information		_____ Change	Effective Date :
1. Name of Home Office as Reported to the IRS		Federal Tax ID Number	
2. Home Office Business Street Address Line 1			
Home Office Business Street Address Line 2			
City		State	ZIP Code
C. Provider's Affiliation to the Chain Home Office		_____ Change	Effective Date :
Check one:			
1. _____ Joint Venture / Partnership	3. _____ Managed / Related	5. _____ Leased	
2. _____ Operated / Related	4. _____ Wholly Owned	6. _____ Other (Specify): _____	

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18 (REV. 10/05) all cost reports submitted to ODJFS will be certified as follows:

**MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.**

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) \_\_\_\_\_, Medicaid Provider Number \_\_\_\_\_ for the cost report period beginning \_\_\_\_\_ and ending \_\_\_\_\_ and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider		Date of Signature	
Print or Type Name of Owner, Officer, or Authorized Representative of Provider			
(Last)	(First)	(M.I.)	
Title	Telephone Number Area code ( )	Fax Number Area Code ( )	
Report Prepared by (Company)			
Report Prepared by (Individual)		Title	
(Last)	(First)	(M.I.)	
Address			
City, State, Zip Code			
Telephone Number of Person Preparing Cost Report Area Code ( )		Fax Number Area Code ( )	
Location of Records or Probable Audit Site		Telephone Number for Audit Contact Person Area Code ( )	
Address		County	
City	State	Zip Code	

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_ at \_\_\_\_\_, county of \_\_\_\_\_, and state of \_\_\_\_\_.

Signature of Notary
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TN 06-010 Approval Date 05/17/07

Supersedes

TN 03-017 Effective Date 07/01/06

SUMMARY OF INPATIENT DAYS

Schedule A-1

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
---------------	--------------------------	------------------------------------------------

**INSTRUCTIONS:** All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January.

Month	Number of Medicaid Certified Beds (1)	Medicaid Patients				Non-Medicaid Patients			Total Inpatient Days (sum of col.5-8) (9)
		Authorized Days (2)	Hospital Leave Days (3)	Therapeutic Leave Days (4)	Total Medicaid Days (sum of col. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January									
2. February									
3. March									
4. April									
5. May									
6. June									
7. July									
8. August									
9. September									
10. October									
11. November									
12. December									
<b>13. TOTAL</b> (sum of lines 1 through 12)									
						Schedule A page 1, line 7 column 2			Schedule A page 1, line 4 column 1

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Schedule A-2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:
---------------	--------------------------	------------------------------------

**INSTRUCTIONS:** Enter gross charges for resident days reported in Schedule A-1 and Attachment 4. These gross charges must be reported from a uniform charge structure applicable to all residents.

Description (1)	Medicare Part B Primary Payer is:		Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
	Medicaid (2)	Other (3)					
<b>SECTION A: REVENUES</b>							
1a. Medical Supplies Revenue							
1b. Percentage (line 1a, each col. 2-7 divided by total on line 1a col. 8)							100%
2a. Medical Minor Equipment							
2b. Percentage (line 2a, each col. 2-7 divided by total on line 2a col. 8)							100%
3a. Enteral Feeding Revenue							
3b. Percentage (line 3a, each col. 2-7 divided by total on line 3a col. 8)							100%
4. TOTAL (Sum of 1a through 3a)							
<b>SECTION B: COSTS</b>							
(1)	MEDICARE PART B OFFSET CALCULATIONS						
	Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)			
5. Percentage of Medicare Part B Charges where primary payer is Medicaid (from Sch A-2, col. 2, applicable line b).							
6. Costs (from Schedule B-1, column 3, lines 1 and 4 and Schedule C column 3 line 10)							
7. Costs to be offset (line 5 times line 6). Offset costs in col. 4 on applicable cost report lines identified in line 6 of this section.							
<b>SECTION C: INDIRECT COST - OFFSET</b>							
8. Indirect costs (Schedule C line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col.3)							
9. Total costs (total of Sch. B-1 line 26, B-2 line 44, C line 63, D lines 11 and 13.)							
10. Line 8 divided by line 9							
11. Costs offset (from line 7 column 5 above)							
12. Indirect cost to be offset (line 10 times line 11) offset costs on Schedule C line 47 column 4							

SUMMARY OF COSTS

Schedule A-3

Provider Name		Medicaid Provider Number	Reporting Period		
			From:	Through:	
REIMBURSABLE COSTS	Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem (Col 3 / 4) (5)
<b>OTHER PROTECTED COSTS</b>					
1. Other Protected Costs use allowable patient days Sch A line 4 Col 1	B-1 line 26 Col 7				
<b>DIRECT CARE COST CENTER</b>					
2. Direct Care Cost use allowable patient days Sch A line 4 Col 1	B-2 line 44 Col 7				
<b>INDIRECT CARE COST CENTER</b>					
3. Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7				
<b>CAPITAL COST CENTER</b>					
<b>COST OF OWNERSHIP</b>					
4. Assets Acquired	D line 11 Col 7				
<b>RENOVATIONS COST CENTER</b>					
5. Renovations	D line 13 Col 7				
6. <b>TOTAL CAPITAL COST</b> (Sum of lines 4 and 5) use allowable patient days Sch A line 6.2 Col 1					
<b>EQUITY</b>					
7. Return on Equity	E-1 line 36 col 5				
8. <b>TOTAL REIMBURSABLE COSTS</b> (sum of lines 1, 2, 3, and 6) Col 3					
9. <b>TOTAL FILED COST PER DIEM</b> (sum of lines 1, 2, 3, 6, and 7) Col 5					

RECONCILIATION OF COSTS

Schedule / Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
10. B-1/26	col 3	col 4	col 5	col 7
11. B-2/44	col 3	col 4	col 5	col 7
12. C/79	col 3	col 4	col 5	col 7
13. D *	col 3	col 4	col 5	col 7
14. Totals	\$ (A)	\$ (B)	\$	\$
15. Less Non-Reimbursable from Schedule C Page 3 line 78			col 5 ( )	col 7 ( )
16. Total Reimbursable			\$ (C)	\$ (C)

\* Summary of Schedule D lines 11 and 13.  
 (A) Agrees to Total Expenses per Working Trial Balance.  
 (B) Agrees to Attachment 2, line 21, column 4, and Schedule A-2, lines 7 and 12, column 5.  
 (C) Agrees to Schedule A-3, line 8, column 3.

NOTE: All cost data should be rounded to the nearest whole dollar.

TN 06-010 Approval Date 05/17/07  
 Supersedes  
 TN 03-017 Effective Date 07/01/06

OTHER PROTECTED COSTS

Schedule B-1

Provider Name		Medicaid Provider Number		Reporting Period					
				From:		Through:			
OTHER PROTECTED COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)	
<b>MEDICAL SUPPLIES</b>									
1. Medical Supplies - medicare billable	6000								
2. Medical Supplies - medicare non-billable	6001								
3. Oxygen - Emergency stand-by	6003								
4. Medical Minor Equip. - medicare billable	6005								
5. Medical Minor Equip. - medicare non-billable	6006								
<b>6. TOTAL Medical Supplies</b> (sum of lines 1 through 5)									
<b>UTILITY COSTS</b>									
7. Heat, Light, Power	6020								
8. Water and Sewage	6030								
9. Trash and Refuse Removal	6040								
10. Hazardous Medical Waste Collection	6050								
<b>11. TOTAL Utility Costs</b> (sum of lines 7 through 10)									
<b>PROPERTY TAXES</b>									
12. Real Estate Taxes	6060								
13. Personal Property Taxes	6070								
14. Franchise Tax (Attach FT 1120)	6080								
15. Commercial Activity Tax (CAT)	6085								
<b>16. TOTAL Property Taxes</b> (sum of lines 12 through 15)									
<b>FRANCHISE PERMIT FEES</b>									
17. Franchise Permit Fees	6091								
<b>HOME OFFICE COSTS</b>									
18. Home Office Costs/Other Protected **	6095								
<b>PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT</b>									
19. Payroll Taxes - Other Protected	6054								
20. Workers Compensation - Other Protected	6055								
21. Employee Fringe Benefits - Other Protected	6056								
22. EAP Administrator - Other Protected	6057								
23. Self Funded Programs Adm. - Other Protected	6058								
24. Staff Development - Other Protected	6059								
<b>25. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development</b> (sum of lines 19 thru 24)									
<b>26. TOTAL Other Protected Costs</b> (sum of lines 6, 11, 16, 17, 18, and 25)									

\*\* Home office costs are to be entered on line 19 only. They are not to be distributed to any other line on this schedule.

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
---------------	--------------------------	------------------------------------------------

DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5+Col 6] (7)
<b>NURSING AND HABILITATION/REHABILITATION</b>								
1. Medical Director	6100							
2. Director of Nursing	6105							
3. RN Charge Nurse	6110							
4. LPN Charge Nurse	6115							
5. Registered Nurse	6120							
6. Licensed Practical Nurse	6125							
7. Nurse Aides	6130							
8. Activity Director	6135							
9. Activity Staff	6140							
10. Program Specialist	6150							
11. Program Director	6155							
12. Habilitation Supervisor	6165							
13. Habilitation Staff	6170							
14. Psychologist	6175							
15. Psychology Assistant	6180							
16. Respiratory Therapist	6185							
17. Social Work/Counseling	6190							
18. Social Services/Pastoral Care	6195							
19. Qualified Mental Retardation Professional	6200							
20. Quality Assurance	6205							
21. Consulting and Management Fees-Direct Care	6210							
22. Active Treatment Off-site Day Programming	6215							
23. Other Direct Care - Specify below	6220							
24. Home Office Costs/Direct Care	6230							
<b>25. TOTAL Nursing and Habilitation/Rehabilitation</b> (sum of lines 1 through 24)								
<b>PURCHASED NURSING SERVICES</b>								
26. Registered Nurse - Purchased Nursing	6300							
27. Licensed Practical Nurse - Purchased Nursing	6310							
28. Nurse Aides - Purchased Nursing	6320							
<b>29. TOTAL Purchased Nursing</b> (sum of lines 25 through 28)								

Line 23 Other Direct Care

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 23, Col 1 and 2		

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

DIRECT CARE COST CENTER

Schedule B-2  
2 of 2

Provider Name		Medicaid Provider Number		Reporting Period					
				From:		Through:			
DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)	
<b>DIRECT CARE THERAPIES</b>									
30. Physical Therapist	6600								
31. Physical Therapy Assistant	6605								
32. Occupational Therapist	6610								
33. Occupational Therapy Assistant	6615								
34. Speech Therapist	6620								
35. Audiologist	6630								
<b>36. TOTAL Direct Care Therapies</b> (sum of lines 30 through 35)									
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT</b> (No Purchased Nursing)									
37. Payroll Taxes - Direct Care	6510								
38. Workers' Compensation - Direct Care	6520								
39. Employee Fringe Benefits - Direct Care	6530								
40. EAP Administrator - Direct Care	6535								
41. Self Funded Programs Admin. - Direct Care	6540								
42. Staff Development - Direct Care	6550								
<b>43. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development</b> (Sum of lines 37 through 42)									
<b>44. TOTAL Reimbursable Direct Care Cost</b> (sum of lines 25, 29, 36, and 43)									

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

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INDIRECT CARE COST CENTER

Schedule C  
1 of 3

Provider Name		Medicaid Provider Number			Reporting Period				
					From:	Through:			
INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other / Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)	
<b>DIETARY COST</b>									
1. Dietitian	7000								
2. Food Service Supervisor	7005								
3. Dietary Personnel	7015								
4. Dietary Supplies and Expenses	7025								
5. Dietary Minor Equipment	7030								
6. Dietary Maintenance and Repair	7035								
7. Food In-Facility	7040								
8. Employee Meals	7045								
9. Contract Meals/Contract Meais Personnel	7050								
10. Enterals: Medicare Billable	7055								
11. Enterals: Medicare Non-billable	7056								
12. Payroll Taxes - Dietary	7060								
13. Workers' Compensation - Dietary	7065								
14. Employee Fringe Benefits - Dietary	7070								
15. EAP Administrator - Dietary	7075								
16. Self Funded Programs Admin. - Dietary	7080								
17. Staff Development - Dietary	7090								
<b>18. TOTAL Dietary</b> (sum of lines 1 through 17)									
<b>MEDICAL, HABILITATION, PHARMACY AND INCONTINENCE SUPPLIES</b>									
19. Habilitation Supplies	7100								
20. Medical/Habilitation Records	7105								
21. Pharmaceutical Consultant	7110								
22. Incontinence Supplies	7115								
23. Personal Care - Supplies	7120								
24. Program Supplies	7125								
<b>25. TOTAL Habilitation, Pharmacy and Incontinence Supplies</b> (sum of lines 19 through 24)									
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>									
26. Administrator	7200								
27. Other Administrative Personnel	7210								
28. Consulting and Management Fees-Indirect	7215								
29. Office and Administrative Supplies	7220								
30. Communications	7225								
31. Security Services	7230								
32. Travel and Entertainment	7235								
<b>33. SUB-TOTAL</b> (sum of lines 26 through 32)									

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

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INDIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number		Reporting Period					
			From:	Through:				
INDIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other / Contract Wages (2)	Total (Col 1+Col 2) (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
<b>ADMINISTRATIVE &amp; GENERAL SERVICES</b>								
34. Laundry/Housekeeping Supervisor	7240							
35. Housekeeping	7245							
36. Laundry and Linen	7250							
37. Universal Precaution Supplies	7255							
38. Legal Services	7260							
39. Accounting	7265							
40. Dues, Subscriptions and Licenses	7270							
41. Interest - Other	7275							
42. Insurance	7280							
43. Data Services	7285							
44. Help Wanted/Informational Advertising	7290							
45. Amortization of Start-Up Costs	7295							
46. Amortization of Organizational Costs	7300							
47. Other Indirect Care - Specify below	7305							
48. Home Office Costs/Indirect Care **	7310							
49. TOTAL Administrative and General Services (sum of lines 34 thru 48 and 33)								
<b>MAINTENANCE AND MINOR EQUIPMENT</b>								
50. Plant Operations/Maintenance Supervisor	7320							
51. Plant Operations and Maintenance	7330							
52. Repair and Maintenance	7340							
53. Minor Equipment	7350							
54. Leased Equipment	7400							
55. TOTAL Maintenance and Minor Equipment (sum of lines 50 through 54)								
<b>PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT</b>								
56. Payroll Taxes - Indirect Care	7500							
57. Workers' Compensation - Indirect Care	7510							
58. Employee Fringe Benefits - Indirect Care	7520							
59. EAP Administrator - Indirect Care	7525							
60. Self Funded Prog. Admin. - Indirect Care	7530							
61. Staff Development - Indirect Care	7535							
62. TOTAL Payroll Taxes, Fringe Benefits, and Staff Development (sum of lines 56 thru 61)								
63. TOTAL Reimbursable Indirect Care Cost (sum of lines 18, 25, 49, 55 and 62)								

Home office costs are to be entered on line 48 only. They are not to be distributed to any other line on this schedule. \*\*

Line 47 Other Indirect Care

Account Title	Salary Column 1	Other Column 2
<b>Totals</b> (must tie to line 47, Cols 1 and 2)		

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

JFS 02524 (REV. 01/2007)

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**INDIRECT CARE COST CENTER**

Schedule C  
3 of 3

Provider Name:		Medicaid Provider Number			Reporting Period From: Through:			
<b>NON-REIMBURSABLE EXPENSES</b>	Chart of Acct	Salary Facility Employed (1)	Other / Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
<b>NON-REIMBURSABLE EXPENSES</b>								
64. Legend Drugs	9705							
65. Radiology	9710							
66. Laboratory	9715							
67. Oxygen	9720							
68. Other Non-Reimbursable - Specify below	9725							
69. Late Fees, Fines or Penalties	9730							
70. Federal Income Tax	9735							
71. State Income Tax	9740							
72. Local Income Tax	9745							
73. Insurance - Officer's Life	9750							
74. Promotional Advertising and Marketing	9755							
75. Contributions and Donations	9760							
76. Bad Debt	9765							
77. Parenteral Nutrition Therapy	9770							
<b>78. TOTAL Non-Reimbursable</b> (sum of lines 64 through 77)								
<b>79. TOTAL Indirect Care Cost</b> <b>Reimbursable and Non-Reimbursable</b> (sum of lines 63 and 78)								

Line 68 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
<b>TOTAL (must tie to line 68, Cols 1 and 2)</b>		

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

Note: All cost data should be rounded to the nearest whole dollar.

ADMINISTRATORS' COMPENSATION

Schedule C-1

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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SECTION A:

First Name of Administrator:	Last Name of Administrator:	Administrator License Number*	Social Security No.
Relationship to Provider			
Is the administrator an owner / relative?		_____ Yes	_____ No
1. Base percentage allowance			100%
2. Years of work experience in related work area, if administrative, must be in health care field (not to exceed 10 years).		_____ Times 4 =	_____ %
3. Years of formal education beyond high school (not to exceed six years if baccalaureate degree is obtained or four years if baccalaureate in not obtained)		_____ Times 5 =	_____ %
3.1 Was baccalaureate degree obtained?	_____ Yes	_____ No	
4. Duties other than those normally performed by this position where a salary is not declared (not to exceed four extra duties)			
a. Accounting	_____		
b. Maintenance	_____		
c. Housekeeping	_____		
d. Other, specify	_____		
e. Other, specify	_____		
Total Duties		_____ Times 4 =	_____ %
5. County Adjustment (see instructions)			_____ %
6. Ownership Points (see instructions)			_____ %
7. Subtotal of lines 1 through 6			_____ %
8. Allowance Percentage (enter line 7, not to exceed 150%).			_____ %

SECTION B:

This Administrator's Dates of Employment During This Reporting Period		Paid Weekly		Compensation		
Beginning Date (MMDDYY)	Ending Date (MMDDYY)	Hrs. **	%	Account Number ***	Column Number	Amount
(1)	(2)	(3)	(4)	(5)	(6)	(7)
<b>TOTAL COMPENSATION</b>						

\* QMRP'S AND ADMINISTRATORS OF HOSPITAL BASED ICFs-MR REPORT SOCIAL SECURITY NUMBER.

\*\* REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED. IF THE AMOUNT IN COLUMN (7) IS ALLOCATED, HOURS PAID MUST BE ALLOCATED USING THE SAME RATIO

\*\*\* THIS SCHEDULE MUST BE COMPLETED FOR ALL ADMINISTRATORS REGARDLESS OF WHETHER THE ADMINISTRATOR'S SALARY IS REPORTED IN ACCOUNT NUMBER 7200 OR ACCOUNT NUMBER 7310. (USE ONLY ACCOUNT NUMBER 7200 OR 7310, WHICHEVER IS APPROPRIATE.)









**COST OF SERVICES FROM RELATED PARTIES**

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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6. Has any director, officer, manager, employee, individual or organization having a direct or indirect ownership interest of 5% or more, been convicted of a criminal or civil offense related to their involvement in programs established by the Title XVIII (Medicare), Title XIX (Medicaid), or Title XX of the Social Security Act as amended?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list names below.

Name	Social Security Number	Name	Social Security Number

7. Has any individual currently under contract with the provider or related party organization been employed in a managerial, accounting, auditing, legal, or similar capacity by the Ohio Department of Job and Family Services, Ohio Department of Health, Office of the Attorney General, the Ohio Department of Aging, the Department of Commerce, or the Department of Industrial Commission within the previous twelve months?

\_\_\_\_\_ Yes \_\_\_\_\_ No If yes, list names below.

Name	Social Security Number	Name	Social Security Number

8. List all contracts in effect during the cost report period for which the imputed value or cost of the service from any individual or organization is ten thousand dollars or more in a twelve month period.

Contractor Name	Contract Amount	Goods or Services Provided

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CAPITAL COST CENTER

Schedule D

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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ASSETS ACQUIRED

COST OF OWNERSHIP (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant and Equip.	8070					
9. Amortization of Financing Costs	8080					
10. Home office Costs/Capital Cost **	8090					
<b>11. TOTAL Cost of Ownership</b> (sum of lines 1 through 10)						

\*\* Home Office Costs are to be entered on line 10 only. They are not to be distributed to any other line in Cost of Ownership.

RENOVATIONS

INSTRUCTIONS: Complete for renovations in use during cost report period reimbursable under Ohio Administrative Code.

RENOVATIONS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
12. Depreciation/Amortization and Interest	8500,8570, 8580					
<b>13. TOTAL Renovations</b>						

\*\*\* If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Schedule D-1

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
---------------	--------------------------	------------------------------------------------

ASSETS ACQUIRED

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period [Col 2 + Col 3] (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 4 - Col 5) (6)	Depreciation this Period (7)
1. Land							
2. Buildings							
3. Land Improvements							
4. Leasehold Improvements							
5. Equipment							
6. Transportation							
7. Financing Costs							
8. TOTAL							

Has there been any change in the original historical cost of capital assets?

\_\_\_\_\_ YES \_\_\_\_\_ NO  
If yes, submit complete detail.

RENOVATIONS

INSTRUCTIONS: Complete for renovations in use during cost report period reimbursable under Ohio Administrative Code.

ACCOUNT	Cost at Beginning of Period (1)	Additions or Reductions (2)	Project Cost End of Period (Col 2 + Col 3) (3)	Accumulated Depreciation End of Period (4)	Net Book Value End of Period [Col 3 - Col 4] (5)	Depreciation/Amortization this Period (6)	Interest this Period (7)	Total Columns 6 and 7 (8)**
9. Depreciation/Amortization and Interest								
10. TOTAL								

\*\* Transfer TOTAL of column 8 to Schedule D, column 3, line 12.



BALANCE SHEET

Schedule E

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
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CURRENT ASSETS	Chart of Acct. No.	BALANCE PER BOOKS	
		Beginning of Period	End of Period
1. Petty Cash	1001		
2. Cash In Banks - General Account	1010		
3. Accounts Receivable	1030		
4. Allowance For Uncollectible Accounts	1040		
5. Notes Receivable	1050		
6. Allowance For Uncollectible Notes Receivable	1060		
7. Other Receivables	1070		
8. Cost Settlement	1080		
9. Inventories	1090		
10. Prepaid Expenses	1100		
11. Short-Term Investments	1110		
12. Special Expenses	1120		
13. <b>Total Current Assets</b> (sum of lines 1 through 12)			
<b>PROPERTY, PLANT AND EQUIPMENT</b>			
14. Property, Plant and Equipment	1200		
15. Accumulated Depreciation And Amortization	1250		
16. Renovations	1300		
17. Accumulated Depreciation And Amortization - Renovations	1350		
18. <b>Total Property, Plant and Equipment</b> (sum of lines 14 through 17)			
<b>OTHER ASSETS</b>			
19. Non-Current Investments	1400		
20. Deposits	1410		
21. Due From Owners/Officers ( to Sch. E-1, pg. 1 of 2, line 2 )	1420		
22. Deferred Charges And Other Assets	1430		
23. Notes Receivable - Long-Term	1440		
24. <b>Total Other Assets</b> (sum of lines 19 through 23)			
25. <b>Total Assets</b> (sum of lines 13, 18 and 24)			
<b>CURRENT LIABILITIES (Report credit balances as positive amounts)</b>			
26. Accounts Payable	2010		
27. Cost Settlements	2020		
28. Notes Payable	2030		
29. Current Portion Of Long-Term Debt	2040		
30. Accrued Compensation	2050		
31. Payroll Related Withholding and Liabilities	2060		
32. Taxes Payable	2080		
33. Other Liabilities - Specify below	2090		
34. <b>Total Current Liabilities</b> (sum of lines 26 through 33)			
<b>LONG-TERM LIABILITIES (Report credit balances as positive amounts)</b>			
35. Long-Term Debt	2410		
36. Related Party Loans - Interest Allowable	2420		
37. Related Party Loans - Interest Non-Allowable ( to Sch E-1, pg 1 of 2, line 3 )	2430		
38. Non-Interest Bearing Loans From Owners ( to Sch. E-1, pg 1 of 2, line 4 )	2440		
39. Deferred Liabilities	2450		
40. <b>Total Long-Term Liabilities</b> (sum of lines 35 through 39)			
41. <b>Total Liabilities</b> (sum of lines 34 and 40)			
42. Capital line 25 less line 41 (to Sch. E-1, pg. 1 of 2, line 1)	3000		
43. <b>TOTAL LIABILITIES AND CAPITAL</b> (must equal line 25)			

Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
<b>TOTALS</b> (must tie to line 33)		

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RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Schedule E-1  
1 of 2

Provider Name:	Medicaid Provider Number	Reporting Period From: _____ Through: _____
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REIMBURSABLE EQUITY	BALANCE PER BOOKS	
	Beginning of Period (1)	End of Period (2)
1. Capital (from Sch. E, line 42)		
2. Due From Owners/Officers ( from Sch. E, line 21 )	( )	( )
3. Related Party Loans - Interest Non-Allowable ( from Sch. E, line 37 )		
4. Non-Interest Bearing Loans From Related Party ( from Sch. E, line 38 )		
5. Equity In Assets Leased From Related Party (attach detail)		
6. Home Office Equity (attach detail)		
7. Cash Surrender Value of Life Insurance Policy	( )	( )
8. Other - Specify:		
9. Other - Specify:		
10. Other - Specify:		
11. Other - Specify:		
12. Other - Specify:		
13. Other - Specify:		
14. Other - Specify:		
15. Other - Specify:		
16. Other - Specify:		
17. Other - Specify:		
18. Other - Specify:		
19. Other - Specify:		
20. Other - Specify:		
21. Other - Specify:		
22. TOTAL Reimbursable Equity (column 1 to E-1, page 2 of 2, line 23, column 2) (column 2 to E-1, page 2 of 2, line 34, column 8)		

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Schedule E-1  
2 of 2

Name of Provider		Medicaid Provider Number	Reporting Period						
			From:		Through:				
Month	Reimbursable Equity Beginning of Period	Capital Investments During Period	Gain (Loss) On Disposal of Assets	Withdrawals, or Dividend Distribution	Other Increase / (Decrease)	Increases or (Decreases) Due to Operations	Reimbursable Equity Capital End of Month (net total of columns 2-7) (8) *		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8) *		
23. January									
24. February									
25. March									
26. April									
27. May									
28. June									
29. July									
30. August									
31. September									
32. October									
33. November									
34. December									
35. Total									
36. Return on Equity	1		2		3		4		5 **
	/		X		/		=		(Ref. Sch. A-3, line 7 col. 5)

\* If the result in Column 8, lines 23 - 34 is a negative figure, enter "0" on lines 23 - 34. Do not enter less than zero.

\*\* Maximum Return on Equity as specified in Ohio Administrative Code

INSTRUCTIONS: completing line 36

- Column # 1 Enter amount from Schedule E-1 line 35 column 8.
- Column # 2 Enter number of months in reporting period.
- Column # 3 Enter Rate of Return Ratio, use 5 decimal places to the right of the decimal.
- Column # 4 Enter allowable capital days from Schedule A line 6.2 column 1.
- Column # 5 Enter result of the previous calculations or the maximum return on equity, whichever is less.

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REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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REVENUE ACCOUNT NAME	Chart of Account	Total	Adjustments Increase (Decrease)	Adjusted Total (Col. 2 + Col. 3)
	(1)	(2)	(3)	(4)
<b>ROUTINE SERVICE - ROOM AND BOARD</b>				
1. Private	5010			
2. Medicare	5011			
3. Medicaid	5012			
4. Veterans	5013			
5. Other	5014			
<b>6. TOTAL (lines 1 through 5)</b>				
<b>DEDUCTIONS FROM REVENUES</b>				
7. Contractual Allowance-Medicare	5710			
8. Contractual Allowance-Medicaid	5720			
9. Contractual Allowance-Other	5730			
10. Charity Allowance	5740			
<b>11. TOTAL (lines 7 through 10)</b>				
<b>THERAPY SERVICES</b>				
12. Physical Therapy	5020			
13. Occupational Therapy	5030			
14. Speech Therapy	5040			
15. Audiology Therapy	5050			
16. Respiratory Therapy	5060			
<b>17. TOTAL (lines 12 through 16)</b>				
<b>MEDICAL SUPPLIES</b>				
18. Medicare B - Medicaid	To Sch. A-2, Line 1a, Col. 2	5070-1		
19. Medicare B - Other	To Sch. A-2, Line 1a, Col. 3	5070-2		
20. Private	To Sch. A-2, Line 1a, Col. 4	5070-3		
21. Medicare A	To Sch. A-2, Line 1a, Col. 5	5070-4		
22. Veterans	To Sch. A-2, Line 1a, Col. 6	5070-5		
23. Other	To Sch. A-2, Line 1a, Col. 6	5070-6		
24. Medicaid	To Sch. A-2, Line 1a, Col. 7	5070-7		
25. Medical Supplies - Routine		5080		
<b>26. TOTAL (lines 18 through 25)</b>				
<b>MEDICAL MINOR EQUIPMENT</b>				
27. Medicare B - Medicaid	To Sch. A-2, Line 2a, Col. 2	5090-1		
28. Medicare B - Other	To Sch. A-2, Line 2a, Col. 3	5090-2		
29. Private	To Sch. A-2, Line 2a, Col. 4	5090-3		
30. Medicare A	To Sch. A-2, Line 2a, Col. 5	5090-4		
31. Veterans	To Sch. A-2, Line 2a, Col. 6	5090-5		
32. Other	To Sch. A-2, Line 2a, Col. 6	5090-6		
33. Medicaid	To Sch. A-2, Line 2a, Col. 7	5090-7		
34. Medical Minor Equipment - Routine		5100		
<b>35. TOTAL (lines 27 through 34)</b>				

REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
---------------	--------------------------	---------------------------	----------

REVENUE ACCOUNT NAME	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
<b>ENTERAL NUTRITION THERAPY</b>				
36. Medicare B - Medicaid	To Sch. A-2, Line 3a, Col. 2	5110-1		
37. Medicare B - Other	To Sch. A-2, Line 3a, Col. 3	5110-2		
38. Private	To Sch. A-2, Line 3a, Col. 4	5110-3		
39. Medicare A	To Sch. A-2, Line 3a, Col. 5	5110-4		
40. Veterans	To Sch. A-2, Line 3a, Col. 6	5110-5		
41. Other	To Sch. A-2, Line 3a, Col. 6	5110-6		
42. Medicaid	To Sch. A-2, Line 3a, Col. 7	5110-7		
43. Enteral Nutrition Therapy - Routine		5120		
<b>44. TOTAL (lines 36 through 43)</b>				
<b>OTHER ANCILLARY SERVICE</b>				
45. Habilitation Supplies		5130		
46. Incontinence Supply		5140		
47. Personal Care		5150		
48. Laundry Service - Routine		5160		
<b>49. TOTAL (lines 45 through 48)</b>				
<b>OTHER SERVICES</b>				
50. Dry Cleaning Service		5310		
51. Communications		5320		
52. Meals		5330		
53. Barber And Beauty		5340		
54. Personal Purchases - Residents		5350		
55. Radiology		5360		
56. Laboratory		5370		
57. Oxygen		5380		
58. Legend Drugs		5390		
59. Other - Specify below		5400		
<b>60. TOTAL (lines 50 through 59)</b>				

Line 59 Other

Account Title	Amount
<b>Total (must tie to line 59, col. 2)</b>	

REVENUE TRIAL BALANCE

Provider Name		Medicaid Provider Number	Reporting Period	
			From:	Through:
REVENUE ACCOUNT NAME	Chart of Account	Total	Adjustments Increase (Decrease)	Adjusted Total (Col. 2 + Col. 3)
	(1)	(2)	(3)	(4)
<b>NON-OPERATING</b>				
61. Management Services	5510			
62. Cash Discounts	5520			
63. Rebates And Refunds	5530			
64. Gift Shop	5540			
65. Vending Machine Revenues	5550			
66. Vending Machine Commissions	5555			
67. Rental - Space	5560			
68. Rental - Equipment	5570			
69. Rental - Other	5580			
70. Interest Income - Working Capital	5590			
71. Interest Income - Restricted Funds	5600			
72. Interest Income - Funded Depreciation	5610			
73. Interest Income - Related Party Revenue	5620			
74. Interest Income - Contributions	5625			
75. Endowments	5630			
76. Gain/Loss On Disposal Of Assets	5640			
77. Gain/Loss On Sale Of Investments	5650			
78. Contributions	5670			
79. <b>TOTAL Non-operating</b> (lines 61 through 78)				
80. <b>TOTAL</b> (sum of Lines 6, 11, 17, 26, 35, 44, 49, 60, and 79)				

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ADJUSTMENT TO TRIAL BALANCE

Attachment 2

Provider Name		Medicaid Provider Number		Reporting Period		
				From:	Through:	
Description	Revenue Chart of Account # (1)	Salary Increase (Decrease) (2)	Other Increase (Decrease) (3)	Total Increase (Decrease) (Col. 2 + Col. 3) (4)	Expense Chart of Account # (5)	Revenue Reference Attachment 1 Line (6)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21. TOTAL						

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Attachment 3

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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As per the cost report instructions, any documentation (required by the Department or needed to clarify individual line items or groupings) must be submitted as hard copy and labeled as an exhibit. To facilitate the reporting and review process of the submitted cost report (including exhibits) ODJFS requires that exhibits 1 through 4 shall be standardized according to the following criteria. Exhibits 1 and 2 are required and shall be labeled accordingly. Exhibits 3 and 4, if needed, shall also be labeled accordingly. In certain situations, if exhibits 3 and 4 are not applicable, the corresponding exhibit number shall not be used. Any other additional exhibit attached will be labeled by number (beginning with 5). Exhibits 1 through 4 are reserved for the specific items as listed below.

**Please attach one copy of the following:**

- Exhibit 1. Facility trial balance that details the general ledger account names as of December 31, 20CY.  
  
IF THE RECOMMENDED CHART OF ACCOUNTS PER OHIO ADMINISTRATIVE CODE IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT.  
(One copy with each cost report is required.)
- Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)
- Exhibit 3. Home office trial balances and the allocation work sheets that show how the home office trial balance is allocated to each individual facility's cost report. Include the account groupings for each home office account. The allocation procedures are pursuant to CMS Publication 15-1 (REV. 11/05), (If applicable - one copy with each cost report is required.)
- Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported. (If applicable - one copy with each cost report is required.)
- Exhibit 5. Any other documentation which is necessary to explain costs. Identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references schedule C, line 8, col. 4.  
  
Failure to cross-reference exhibits, to the applicable cost report schedule, line, and column qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to Ohio Administrative Code.

PAID NON-MEDICAID LEAVE DAYS

Attachment 4

Provider Name	Medicaid Provider Number	Reporting Period
		From: Through:

**INSTRUCTIONS:** Record monthly the non-Medicaid leave days paid for by payers other than ODJFS. Paid non-Medicaid leave days are hospital, therapeutic, or any other leave day paid for on behalf of a non-Medicaid resident. Non-Medicaid leave days are counted as inpatient days proportionate to the non-Medicaid per diem rate paid.

MONTH	TOTAL PAID NON-MEDICAID LEAVE DAYS
JANUARY	
FEBRUARY	
MARCH	
APRIL	
MAY	
JUNE	
JULY	
AUGUST	
SEPTEMBER	
OCTOBER	
NOVEMBER	
DECEMBER	
TOTAL	

Percentage of per diem rate paid by non-Medicaid residents for leave days

\_\_\_\_\_

WAGE AND HOURS SURVEY

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through _____
---------------	--------------------------	-----------------------------------------------

**INSTRUCTIONS:** REPORT THE NUMBER OF HOURS CONSISTENT WITH THE AMOUNT OF COMPENSATION REPORTED.

Column (C): Enter wages (net of adjustments) paid to facility personnel (This must agree with the sum of column 1 on schedules B-1, B-2, C and attachment 2, column 2).

Column (D): Enter total wages paid to an owner of the facility as reported on C-2 (This must agree with schedule C-2).

Column (E): Column (C) minus Column (D).

Column (F): Enter total hours that correspond with the total wages reported in column (C).

Column (G): Enter total hours that correspond with the total wages reported in column (D).

Column (H): Column (F) minus column (G).

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>OTHER PROTECTED COSTS</b>							
1. Water and Sewage (salary only)	6030						
1a. EAP Administrator - Other Protected	6057						
1b. Self Funded Programs Adm. - Other Protected	6058						
1c. Staff Development - Other Protected	6059						
<b>1d. TOTAL Other Protected (sum of lines 1 - 1c)</b>							
<b>DIRECT CARE NURSING AND HABILITATION/REHABILITATION</b>							
2. Medical Director	6100						
3. Director of Nursing	6105						
4. RN Charge Nurse	6110						
5. LPN Charge Nurse	6115						
6. Registered Nurse	6120						
7. Licensed Practical Nurse	6125						
8. Nurse Aides	6130						
9. Activity Director	6135						
10. Activity Staff	6140						
11. Program Specialist	6150						
12. Program Director	6155						
13. Habilitation Supervisor	6165						
14. Habilitation Staff	6170						
15. Psychologist	6175						
16. Psychology Assistant	6180						
17. Respiratory Therapist	6185						
18. Social Work/Counseling	6190						
19. Social Services/Pastoral Care	6195						
20. Qualified Mental Retardation Professional	6200						
21. Quality Assurance	6205						
22. Other Direct Care (salary)	6220						
23. Home Office Costs/Direct Care (salary)	6230						
<b>24. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 2 through 23)</b>							
<b>25. TOTAL Page 1 (sum of lines 1d and 24)</b>							

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WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
				From:	Through		
WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>DIRECT CARE THERAPIES</b>							
26. Physical Therapist	6600						
27. Physical Therapy Assistant	6605						
28. Occupational Therapist	6610						
29. Occupational Therapy Assistant	6615						
30. Speech Therapist	6620						
31. Audiologist	6630						
32. TOTAL Direct Care Therapies (sum of lines 26 through 31)							
<b>PAYROLL TAX, FRINGE BENEFITS AND STAFF DEVELOPMENT (No Purchased Nursing)</b>							
33. EAP Administrator - Direct Care	6535						
34. Self Funded Programs Adm. - Direct Care	6540						
35. Staff Development - Direct Care	6550						
36. TOTAL Payroll Tax, Fringe Benefits and Staff Development (sum of lines 33 through 35)							
<b>DIETARY COST</b>							
37. Dietitian	7000						
38. Food Service Supervisor	7005						
39. Dietary Personnel	7015						
40. EAP Administrator - Dietary	7075						
41. Self Funded Programs Admin. - Dietary	7080						
42. Staff Development - Dietary	7090						
43. TOTAL Dietary Cost (sum of lines 37 through 42)							
<b>HABILITATION AND PHARMACEUTICAL</b>							
44. Medical / Habilitation Records	7105						
45. Pharmaceutical Consultant	7110						
46. TOTAL Habilitation and Pharmaceutical (sum of lines 44 and 45)							
47. TOTAL Page 2 (sum of lines 32, 36, 43 and 46)							

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WAGE AND HOURS SURVEY

Provider Name		Medicaid Provider Number		Reporting Period			
				From:	Through		
WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
<b>ADMINISTRATIVE AND GENERAL SERVICES</b>							
48. Administrator	7200						
49. Other Administrative Personnel	7210						
50. Security Services (salary only)	7230						
51. Laundry/Housekeeping Supervisor	7240						
52. Housekeeping	7245						
53. Laundry and Linen	7250						
54. Accounting	7265						
55. Data Services (salary only)	7285						
56. Other Indirect Care (salary only)	7305						
57. Home Office Costs/Indirect Care (salary)	7310						
<b>58. TOTAL Administrative and General Services</b> (sum of lines 48 through 57)							
<b>MAINTENANCE AND MINOR EQUIPMENT</b>							
59. Plant Operations / Maintenance Sup.	7320						
60. Plant Operations and Maintenance	7330						
<b>61. TOTAL Maintenance and Minor Equipment</b> (sum of lines 59 and 60)							
<b>PAYROLL TAXES, FRINGE BENEFITS &amp; STAFF DEVELOPMENT</b>							
62. EAP Administrator - Indirect Care	7525						
63. Self Funded Prog. Admin.-Indirect Care	7530						
64. Staff Development - Indirect Care	7535						
<b>65. TOTAL Payroll Taxes, Fringe Benfits, and Staff Development</b> (sum of lines 62 thru 64)							
<b>66. TOTAL Page 3</b> (sum of lines 58, 61 and 65)							
<b>67. TOTAL ATTACHMENT 6</b> Pages 1, 2 and 3 (sum of lines 25, 47 and 66)							

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ADDENDUM FOR DISPUTED COSTS

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
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**INSTRUCTIONS:** This attachment is for the reporting of costs as specified in the Ohio Revised Code that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From" columns, the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.
2. Enter in the "Reclassification To" columns, the schedule, line number, and reason you believe these costs should be reclassified.

CURRENT COST CENTERS	Reclassification From:				Reclassification To:		
	Chart of Acct.	Salary Facility Employed (1)	Other/ Contract Wages (2)	Adjusted Allocated Total (3)	Schedule (4)	Line (5)	Reason (6)
<b>OTHER PROTECTED COSTS</b>							
1.							
2.							
3.							
4.							
<b>5. TOTAL Other Protected Costs</b> (sum of lines 1 through 4)							
<b>DIRECT CARE COST CENTER</b>							
6.							
7.							
8.							
9.							
<b>10. TOTAL Direct Care Costs</b> (sum of lines 6 through 9)							
<b>INDIRECT CARE COST CENTER</b>							
11.							
12.							
13.							
14.							
<b>15. TOTAL Indirect Care Costs</b> (sum of lines 11 through 14)							
<b>NON-REIMBURSABLE EXPENSES</b>							
16.							
17.							
18.							
19.							
<b>20. TOTAL Non-Reimbursable Expenses</b> (sum of lines 16 through 19)							
<b>CAPITAL COST CENTER</b>							
21.							
22.							
23.							
24.							
<b>25. TOTAL Capital Cost</b> (sum of lines 21 through 24)							
<b>26. TOTAL COST CENTERS</b> (sum of lines 5, 10, 15, 20, and 25)							

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5101:3-3-71.2 Intermediate care facilities for the mentally retarded (ICFs-MR): leased employees.

(A) "Leased staff services" means services provided by staff who are furnished to an ICF-MR by a leasing firm under contract with the facility.

(B) Costs related to staff leasing are reimbursable as other/contracted costs if all of the following apply:

(1) The ICF-MR has contracted for leased staff through an established staff leasing firm. An established staff leasing firm is one that is, and over a period of time has been, in the business of leasing staff in a variety of industries. Individuals with a variety of skills are generally included in the contractual agreement between the long-term care facility and the staff leasing firm.

(2) The leased staff are present in the ICF-MR on a consistent basis. It is the responsibility of the provider to maintain documentation showing continuity in staff.

(3) The contract between the ICF-MR and the staff leasing firm is for a period of one year or more.

(4) The ICF-MR maintains control over the day-to-day management of leased staff.

(C) Staff leasing arrangements are reimbursable through the medicaid NF and ICF-MR cost reporting mechanism in the following manner.

(1) The wage component of fees paid to the staff leasing firm are reported in the direct care, indirect care, and other protected cost centers in other/contract wages (column 2) of the medicaid cost report for the applicable accounts as defined in rule 5101:3-3-71 of the Administrative Code.

(2) The payroll taxes and employee benefits portion of fees paid to the staff leasing firm are reported in the direct care, indirect care, and other protected cost centers in other/contract wages (column 2) of the medicaid cost report for the applicable accounts as defined in rule 5101:3-3-71 of the Administrative Code on the basis of dollars allocated to the appropriate employee benefit and payroll accounts.

(3) The payroll administration portion of fees paid to the staff leasing firm not identified as wages or benefits are reported in account 7305 administrative and general services, other indirect care (column 2) of the medicaid cost report as defined in rule 5101:3-3-71 of the Administrative Code. Payroll administration fees paid to a staff leasing firm meeting the definition of related parties as defined in rule 5101:3-3-01 of the Administrative Code are not reimbursable beyond those expenses that would be reimbursable if incurred by the provider itself.

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(D) It is the provider's responsibility to maintain adequate documentation of the staff leasing costs.

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5101:3-3-71.3

**Capital asset and depreciation guidelines - intermediate care facilities for the mentally retarded (ICFs-MR).**

- (A) A per diem for depreciation on buildings, components, and equipment used in the provision of patient care that are not reimbursable by medicaid directly to the medical equipment supplier in accordance with rule 5101:3-3-19 of the Administrative Code is an allowable cost.
- (B) For purposes of determining if an expenditure should be capitalized, the following guidelines are utilized:
- (1) Any expenditure for an item that costs five hundred dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life.
  - (2) A provider may use a capitalization policy less than five hundred dollars per item, but is required to obtain prior approval from the Ohio department of job and family services (ODJFS) if the provider wishes to change its capitalization policy from its initial capitalization policy.
- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, ICFs-MR shall use the table as set forth in appendix A of this rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in appendix A of this rule, the internal revenue service publication 946 "How to Depreciate Property" (rev. 2004) shall be used for purposes of determining the useful life of that capital asset.
- (E) The following depreciation conventions shall be used to calculate depreciation expense:
- (1) For calendar year 1994 and each calendar year thereafter, in the month that a capital asset is placed into service, no depreciation expense is recognized as an allowable expense. A full month's depreciation expense is recognized in the month following the month the asset is placed into service.
  - (2) In the month that the capital asset is disposed, if the capital asset is not fully depreciated, the allowable depreciation expense is recognized as it is defined in section 132 of the centers for medicare and medicaid services (CMS) publication 15-1 "Provider Reimbursement Manual" (Rev. 1/05). At no time shall an asset be depreciated more than its adjusted basis.
- (F) Providers shall maintain detailed depreciation schedules to verify each individual capital asset placed in service.

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**Attachment 4.19D  
Supplement 2**

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APPENDIX A  
ENACTED

## ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFELAND IMPROVEMENTS

BUMPERS	5
CULVERTS	18
FENCING	
BRICK OR STONE	25
CHAIN-LINK	15
WIRE	5
WOOD	8
FLAG POLE	20
GUARD RAILS	15
HEATED PAVEMENT	10
LANDSCAPING	10
LAWN SPRINKLER SYSTEM	15
PARKING LOT, OPEN-WALL	20
PARKING LOT GATE/S	3
PARKING LOT STRIPING	2
PAVING (INCLUDING ROADWAYS, WALKS, AND PARKING)	
ASPHALT	8
BRICK	20
CONCRETE	15
GRAVEL	5
RETAINING WALL	20
SEPTIC SYSTEM	15
SHRUBS AND LAWNS	5
SIGNS, METAL OR ELECTRIC	10
SNOW-MELTING SYSTEM	5
TREES	20
TURF, ARTIFICIAL	5
UNDERGROUND UTILITIES	
SEWER LINES	25
WATER WELLS	25
YARD LIGHTING	15

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APPENDIX A  
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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

BUILDINGS - ALL 40

BUILDING COMPONENTS

CANOPIES	15
CARPENTRY WORK	15
CAULKING	10
CEILING FINISHES	
GYPSUM	10
PLASTER	12
COMPUTER FLOORING	10
CORNER GUARDS	10
CUBICLE TRACKS	20
DESIGNATION SIGNS	5
DOORS AND FRAMES	
AUTOMATIC	10
HOLLOW METAL	20
WOOD	15
DRAPERY TRACKS	10
DRILLED PIERS	40
FLOOR FINISHES	
CARPET	5
CERAMIC	20
CONCRETE	20
QUARRY	20
TERRAZZO	15
VINYL	10
FOLDING PARTITIONS	10
INTERIOR FINISHES	15
LOADING DOCK BUMPERS AND LEVELERS	10
MILLWORK	15
OVERHEAD DOORS	10
PARTITIONS, INTERIOR	15
PARTITIONS, TOILET	20
RAILINGS	
FREESTANDING (EXTERIOR)	15
HANDRAILS (INTERIOR)	15
ROOF COVERING	10
SKYLIGHTS	20
STOREFRONT CONSTRUCTION	20

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APPENDIX A  
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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

WALL COVERING	
PAINT	5
WALLPAPER	5
X-RAY PROTECTION	10

FIXED EQUIPMENT

BENCHES, BINS, CABINETS, COUNTERS, AND SHELVING, BUILT-IN	20
CABINET, BIOLOGICAL SAFETY	15
CANOPY-VENTILATING FOR LAUNDRY IRONER	15
COAT RACK	20
CONVEYOR SYSTEM, LAUNDRY	10
COOLER, WALK-IN	15
CURTAINS AND DRAPES	5
EMERGENCY GENERATOR SET	20
GENERATOR CONTROLS	12
HOOD, FUME	15
FIRE PROTECTION IN HOODS	10
ICU AND CCU COUNTERS	15
ILLUMINATOR	
MULTIFILM	10
SINGLE	10
LAMINAR FLOW SYSTEM	15
LOCKERS, BUILT-IN	15
MAILBOXES, BUILT-IN	20
MEDICINE PREPARATION STATION	15
MIRRORS, TRAFFIC AND/OR WALL MOUNTED	10
NARCOTICS SAFE	20
NURSES' COUNTER, BUILT-IN	15
PASS-THROUGH BOXES	15
PATIENTS' CONSOLES	15
PATIENTS' WARDROBES AND VANITIES, BUILT-IN	15
PROJECTION SCREENS	10
SINK AND DRAINBOARD	20
STERILIZER, BUILT-IN	15
TELEPHONE ENCLOSURE	10

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APPENDIX A  
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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

BUILDING SERVICES EQUIPMENT

AIR-CONDITIONING EQUIPMENT

CENTRIFUGAL CHILLER	15
COMPRESSOR, AIR	15
CONDENSATE TANK	10
CONDENSER	15
CONTROLS	10
COOLER AND DEHUMIDIFIER	10
COOLING TOWER	
METAL	20
WOOD	20
DUCT WORK	20
FAN, AIR-HANDLING AND VENTILATING	20
PIPING	20
PRECIPITATOR	10
PUMP	10

AIR-CONDITIONING SYSTEM

LARGE (OVER 20 TONS)	10
MEDIUM (5-20 TONS)	10
SMALL (UNDER 5 TONS)	5

AIR CURTAIN

15

ANTENNA SYSTEM

10

BOILER

20

    DEAERATOR SYSTEM

15

BOILER SMOKESTACK, METAL

20

CLEAN-AIR EQUIPMENT

15

CLOCK SYSTEM, CENTRAL

15

DOOR ALARM

10

DOOR-CLOSING DEVICES, FOR FIRE ALARM SYSTEM

15

ELECTRIC LIGHTING AND POWER

COMPOSITE 18

CONDUIT AND WIRING 20

EMERGENCY LIGHTING SYSTEM 15

FEED WIRING 20

FIXTURES 10

SWITCH GEAR 15

TRANSFORMER 20

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APPENDIX A  
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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

ELEVATOR	
DUMBWAITER	20
FREIGHT	20
PASSENGER, HIGH-SPEED AUTOMATIC	20
PASSENGER, OTHER	20
EMERGENCY GENERATOR	20
CONTROLS	12
ESCALATOR	20
FANS, CEILING-MOUNTED	10
FIRE PROTECTION SYSTEM	
FIRE ALARM SYSTEM	10
FIRE PUMP	20
SMOKE AND HEAT DETECTORS	10
SPRINKLER SYSTEM	25
TANK AND TOWER	25
FURNACE, DOMESTIC	15
HEATING, VENTILATING, AND AIR-CONDITIONING (COMPOSITE SYSTEM)	15
HUMIDIFIER	15
INCINERATOR, INDOOR	10
INSULATION, PIPE	15
INTERCOM SYSTEM	10
LABORATORY PLUMBING, PIPING	20
MAGNETIC DOOR HOLDERS	10
MEDICAL GAS PANELS	10
NURSE CALL SYSTEM	10
OIL STORAGE TANK	20
OXYGEN, GAS, AND AIR PIPING	20
PAGING SYSTEM	10
PHYSICIAN'S IN-AND-OUT REGISTER, BUILT-IN	10
PLUMBING, COMPOSITE	20
FIXTURES	20
PIPING	25
PUMP	15
PNEUMATIC TUBE SYSTEM	15
RADIATOR	
CAST-IRON	25
FINNED TUBE	15
SEWERAGE, COMPOSITE	25
PIPING	20
SUMP PUMP AND SEWERAGE EJECTOR	10
SOLAR HEATING EQUIPMENT	10

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USEFUL LIFE

SURGE SUPPRESSING SYSTEM	15
TELEPHONE SYSTEM	10
TELEVISION ANTENNA SYSTEM	10
TELEVISION SATELLITE DISH	10
TEMPERATURE CONTROLS, COMPUTERIZED	10
UNIT HEATER	10
VACUUM CLEANING SYSTEM	15
WATER FOUNTAIN	10
WATER HEATER, COMMERCIAL	10
WATER PURIFIER	10
WATER SOFTENER	10
WATER STORAGE TANK	20
WATER WELLS	25

ALPHABETIZED LIST OF EQUIPMENT ITEMS

ACCELERATOR	7
ACCOUNTING/BOOKKEEPING MACHINE	5
ADDING MACHINE	5
AIR-CONDITIONER, WINDOW	5
ALTERNATING PRESSURE PAD	10
AMBULANCE	4
AMINO ACID ANALYZER	7
AMPLIFIER	10
ANAEROBE CHAMBER	15
ANALYZER, HEMATOLOGY	7
ANATOMICAL MODEL	10
ANESTHESIA UNIT	7
ANKLE EXERCISER	15
APNEA MONITOR	7
APRON, LEAD-LINED	4
ARTHROSCOPE	5
ARTHROSCOPY INSTRUMENTATION	3
ASPIRATOR	10
AUDIOMETER	10
AUTOCLAVE	10
AUTOMOBILE	
DELIVERY	4
PASSENGER	4
AUTOSCALER, IONIC	10

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	<u>USEFUL LIFE</u>
BACTERIOLOGY ANALYZER	8
BACTI INCINERATOR	5
BALANCE	
ANALYTICAL	10
ELECTRONIC	7
PRECISION MECHANICAL	10
BASAL METABOLISM UNIT	8
BASSINET	15
BATH	
PARAFFIN	7
SEROLOGICAL	7
SITZ	10
WATER	7
WHIRLPOOL	10
BATTERY CHARGER	5
BED	
BIRTHING	10
ELECTRIC	12
FLOTATION THERAPY	10
HYDRAULIC	15
LABOR	15
MANUAL	15
ORTHOPEDIC	15
BEDPAN WASHER	15
BEEPERS, PAGING	3
BENCH, METAL OR WOOD	15
BIN, METAL OR WOOD	15
BINDER, PUNCH MACHINE	10
BIOCHEMICAL ANALYSIS UNIT	7
BIOCHROMATIC ANALYZER	7
BIOFEEDBACK MACHINE	8
BIOMAGNETOMETER	7
BIPOLAR COAGULATOR	7
BLANKET DRYER	15
BLANKET WARMER	15
BLOOD CELL COUNTER	5
BLOOD CHEMISTRY ANALYZER, AUTOMATED	5
BLOOD CULTURE ANALYZER	8
BLOOD GAS ANALYZER	5
BLOOD GAS APPARATUS, VOLUMETRICS	8
BLOOD PRESSURE DEVICE, ELECTRONIC	6

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USEFUL LIFE

BLOOD TRANSFUSION APPARATUS	6
BLOOD WARMER	7
BLOOD WARMER COIL	7
BONE SURGERY APPARATUS	3
BOOKCASE, METAL OR WOOD	20
BOTTLE WASHER	10
BREATHING UNIT, POSITIVE-PRESSURE	8
BROILER 10	
BRONCHOSCOPE	
FLEXIBLE	3
RIGID	3
BULLETIN BOARD	10
BURNISHER, SILVERWARE	15
CABINET	
BEDSIDE	15
FILE	15
INSTRUMENT	15
METAL OR WOOD	15
PHARMACY	15
SOLUTION	15
X-RAY	15
CAGE, ANIMAL	10
CALCULATOR	5
CAMERA	
IDENTIFICATION	5
SURGICAL	5
TELEVISION MONITORING, COLOR OR BLACK-AND-WHITE	5
VIDEOTAPE, COLOR OR BLACK-AND-WHITE	5
CAN OPENER, ELECTRIC	10
CAPSULE MACHINE	10
CARBON MONOXIDE RECORDER/DETECTOR	10
CARDIAC MONITOR	5
CARDIOSCOPE	8
CART	
EMERGENCY-ISOLATION	10
FOOD/TRAY, HEATED-REFRIGERATED	10
LINEN	10
MAID	10
MEDICINE	10
SUPPLY	10
UTILITY	10

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USEFUL LIFE

CASH REGISTER	5
CASPAR ACF INSTRUMENT AND PLATE SYSTEM	7
CASSETTE CHANGER	8
CATHODE-RAY TUBE (CRT)	3
CAUTERY UNIT	
DERMATOLOGY	7
GYNECOLOGY	7
CELL FREEZER	7
CELL WASHER	5
CENTRAL DATA PROCESSING UNIT	10
CENTRAL SUPPLY FURNITURE	15
CENTRIFUGE	7
REFRIGERATED	5
CEREBRAL FUNCTION MONITOR	7
CHAIR	
BLOOD DRAWING	10
DENTAL	15
EXECUTIVE	15
FOLDING	10
GERIATRIC	10
HYDRAULIC, SURGEON'S	15
KINETRON	15
PODIATRIC	15
SHOWER/BATH	10
SIDE	15
SPECIALIST'S	15
CHART RACK	20
CHART RECORDER	10
CHECK SIGNER	10
CHILD IMMOBILIZER	15
CHLORIDIOMETER	10
CHROMATOGRAPH, GAS	7
CLINICAL ANALYZER	5
CLOCK	10
CLOPAY WRAPPING MACHINE	10
CLOTHES LOCKER	
FIBERGLASS OR METAL	15
LAMINATE OR WOOD	12
COAGULATION ANALYZER	5
COFFEE MAKER	5
COLD-PACK UNIT, FLOOR	10

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COLLATOR, ELECTRIC	10
COLONOSCOPE	3
COLORIMETER	7
COLPOSCOPE, WITH FLOOR STAND	8
COMPACTOR, WASTE	10
COMPRESSOR, AIR	12
COMPUTER	
CARDIAL OUTPUT	5
CLINICAL	5
DISK DRIVE	5
LARGE	5
MICRO	5
MINI (PERSONAL)	5
PRINTER	5
SOFTWARE	5
TERMINAL	5
COMPUTER-ASSISTED TOMOGRAPHY (CT) SCANNER	5
CONDUCTIVITY TESTER	5
CONVEYOR, TRAY	10
COOKER, PRESSURE, FOR FOOD	10
COOLER, WALK-IN, FREESTANDING	15
CO-OXIMETER	10
CREDENZA	15
CRIB	15
CROUPETTE	10
CRYOPHTHALMIC UNIT, WITH PROBES	7
CRYOSTAT	7
CRYOSURGICAL UNIT	10
CUTTER	
CLOTH, ELECTRIC	10
FOOD	10
CYCLOTRON	7
CYSTIC FIBROSIS TREATMENT SYSTEM	10
CYSTOMETER	10
CYSTOMETROGRAM UNIT	10
CYSTOSCOPE	3
DATA CARD PROCESSING UNIT - (INCLUDING KEYPUNCH, VERIFIER, READER, AND SORTER)	5
DATA PRINTING UNIT	5

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USEFUL LIFE

DATA STORAGE UNIT	
MECHANICAL	10
NONMECHANICAL	15
DATA TAPE PROCESSING UNIT - (INCLUDING CONTROLLER, DRIVE, AND TAPE DECK)	5
DECALCIFIER	10
DEFIBRILLATOR	5
DEIONIZED WATER SYSTEM	7
DENSITOMETER, RECORDING	5
DENTAL DRILL, WITH SYRINGE	3
DERMATOME	10
DESK, METAL OR WOOD	20
DIAGNOSTIC SET	10
DIATHERMY UNIT	10
DICTATING EQUIPMENT	5
DIGITAL FLUOROSCOPY UNIT	5
DIGITAL RADIOGRAPHY UNIT	5
DILUTER 10	
DISH STERILIZER	10
DISHWASHER	10
DISINFECTOR	10
DISPENSER	
ALCOHOL	10
BUTTER, REFRIGERATED	10
MILK OR CREAM	10
DISPLAY CASES	20
DISTILLING APPARATUS	15
DOPPLER	5
DOSE CALIBRATOR	5
DRESSER	15
DRILL PRESS	20
DRYER	
CLOTHES	10
HAIR	5
SONIC	10
DRYING OVEN, PAINT SHOP	10
DUPLICATOR	5
ECHOCARDIOGRAPH SYSTEM	5
ECHOVIEW SYSTEM	5
ELECTROCARDIOGRAPH	7
ELECTROCARDIOSCANNER (HOLTER MONITOR SCANNER)	7

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ELECTROENCEPHALOGRAPH	7
ELECTROLYTE ANALYZER	5
ELECTROMYOGRAPH	7
ELECTROPHORESIS UNIT	7
ELECTROSURGICAL UNIT	7
ENLARGER	10
ERGOMETER	10
EVACUATOR	10
EVOKED POTENTIAL UNIT	10
EXERCISE APPARATUS	15
EXERCISE EQUIPMENT, OUTDOOR	10
EXERCISE SYSTEM, COMPUTER-ASSISTED	5
EXERCISER, ORTHOTRON	10
EXTRACTOR, LAUNDRY	15
EYE SURGERY EQUIPMENT (PHACOEMULSIFIER)	7
FACSIMILE TRANSMITTER	3
FIBEROPTIC EQUIPMENT	5
FIBROMETER	7
FILES, ELECTRIC ROTARY	15
FILING SYSTEM, PORTABLE	20
FILM CHANGER	8
FILM VIEWER	10
FLOOR-BUFFING AND POLISHING MACHINE	5
FLOOR-SCRUBBING MACHINE	5
FLOOR-WAXING MACHINE	5
FLOW CYTOMETER	5
FLUID SAMPLE HANDLER	5
FLUORIMETER	10
FLUOROSCOPE	8
FOLDER, FLATWORK	15
FOOD CHOPPER	10
FOOD SERVICE FURNITURE	15
FRAME, TURNING	15
FREEZER, ULTRACOLD	10
FRYER, DEEP-FAT	10
FURNACE, LABORATORY	10
GAMMA CAMERA	5
GAMMA COUNTER	7
GAMMA KNIFE	10
GAMMA WELL SYSTEM	7
GARBAGE DISPOSAL, COMMERCIAL	5

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USEFUL LIFE

GAS ANALYZER	8
GEIGER COUNTER	10
GENERATOR	5
GLASSWARE WASHER	8
GLOVES, LEAD-LINED	3
GRAPHOTYPE	15
GRIDDLE	10
GRINDER, FOOD WASTE	10
HAND DYNAMOMETER	10
HEART-LUNG SYSTEM	8
HEAT SEALER	5
HELICOPTER	4
HEMODIALYSIS UNIT	5
HEMOGLOBINOMETER	7
HEMOPHOTOMETER	10
HIGH-DENSITY MOBILE FILM SYSTEM	10
HOIST, CHAIN OR CABLE	12
HOLTER	
ELECTROCARDIOGRAPH	7
ELECTROENCEPHALOGRAPH	7
HOMOGENIZER	10
HOOD, EXHAUST OR BACTI	10
HOT-FOOD BOX	15
HOTPLATE	5
HOUSEKEEPING FURNITURE	15
HUMIDIFIER	8
HYDROCOLLATOR	10
HYDROTHERAPY EQUIPMENT	15
HYFRECATOR	10
HYPERBARIC CHAMBER	15
HYPOTHERMIA APPARATUS	10
ICE CREAM FREEZER	10
ICE CREAM (SOFT) MACHINE	10
ICE CREAM STORAGE CABINET	10
ICE CUBE-MAKING EQUIPMENT	10
ICU AND CCU FURNITURE	15
IMAGE ANALYZER	5
IMAGE INTENSIFIER	5
IMMUNODIFFUSION EQUIPMENT	10

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USEFUL LIFE

IMPRINTER	
ADDRESS	5
EMBOSSED PLATE	10
IMX ANALYZER	7
INCUBATOR	
LABORATORY	10
NURSERY	10
INDICATOR, REMOTE	10
INFANT CARE CENTER	10
INHALATOR	10
IN-SERVICE EDUCATION FURNITURE	15
INSUFFLATOR	5
INTEGRATOR	10
INTERCOM	10
INTRAARTERIAL SHAVER	10
IONTOPHORESIS UNIT	8
IRONER, FLATWORK	15
ISODENSITOMETER	7
ISOLATION CHAMBER	12
ISOTOPE EQUIPMENT	7
ISOTOPE SCANNER	7
KETTLE, STEAM-JACKETED	15
KEY MACHINE	10
KILN	10
K-PADS	5
KYMOGRAPH	10
LABEL MAKER	10
LABOR AND DELIVERY FURNITURE	15
LABORATORY FURNITURE	15
LAMINATOR	10
LAMP	
BILIRUBIN	10
DEEP-THERAPY	10
EMERGENCY	10
INFRARED	10
MERCURY QUARTZ	10
SLIT	10
LAPAROSCOPE	3
LARYNGOSCOPE	3

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USEFUL LIFE

LASER	
CORONARY	2
SURGICAL	5
LASER POSITIONER	5
LASER SMOKE EVACUATOR	5
LATHE	15
LAWN AND PATIO FURNITURE	5
LAWN MOWER, POWER	3
LIBRARY FURNITURE	20
LIFTER, PATIENT	10
LIGHT	
DELIVERY	15
EXAMINING	10
PORTABLE, EMERGENCY	10
LINAC SCALPEL	5
LINEAR ACCELERATOR	7
LINEN	
DRYER	15
PRESS	15
TABLE	15
WASHER	15
LINT COLLECTOR	15
LITHOTRIPTER, EXTRACORPOREAL SHOCK-WAVE (ESWL)	5
LOOM	15
LOWERATOR	10
MAGNETIC RESONANCE IMAGING (MRI) EQUIPMENT	5
MAILING MACHINE	10
MAMMOGRAPHY UNIT	
FIXED	5
MOBILE (VAN)	8
MANNEQUIN	10
MARKING MACHINE	10
MAROGRAPH	7
MASS SPECTROPHOTOMETER	7
MEAT CHOPPER	10
MICROBIOLOGY ANALYZER	8
MICROFILM UNIT	10
MICROPHONE	5
MICROPROJECTOR	10
MICROSCOPE	7
MICROTOME	7

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	<u>USEFUL LIFE</u>
MICROTRON POWER SYSTEM	7
MIRROR, THERAPY	15
MIXER, COMMERCIAL	10
MUSCLE STIMULATOR	10
NATURAL CHILDBIRTH BACKREST	10
NEBULIZER	
PNEUMATIC	10
ULTRASONIC	10
NEPHROSCOPE	7
NEUROLOGICAL SURGICAL TABLE HEADREST	10
NEUTRON BEAM ACCELERATOR	8
NONINVASIVE CO2 MONITOR	7
NOURISHMENT ICE STATION	8
NURSING SERVICE FURNITURE	15
OFFICE FURNITURE	12
OPERATING ROOM FURNITURE	15
OPERATING STOOL	15
OPHTHALMOSCOPE	10
OPTICAL READERS	5
ORGAN	10
ORTHOTRON SYSTEM	10
ORTHOUROLOGICAL INSTRUMENTS	10
OSCILLOSCOPE	7
OSMOMETER	7
OTOSCOPE	7
OTTOMAN	10
OVEN	
BAKING	10
MICROWAVE	5
PARAFFIN	10
ROASTING	10
STERILIZING	10
OXIMETER	10
OXYGEN ANALYZER	7
OXYGEN TANK, MOTOR, AND TRUCK	8
PACEMAKER, CARDIAC (EXTERNAL)	5
PACING SYSTEM ANALYZER	7
PACKAGING MACHINE	10
PAINT SPRAY BOOTH	15
PAINT-SPRAYING MACHINE	10
PANENDOSCOPE	10

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USEFUL LIFE

PAPER BALER	15
PAPER BURSTER	8
PAPER CUTTER	10
PAPER JOGGER	10
PAPER SHREDDER	5
PARALLEL BARS	15
PARKING LOT SWEEPER	5
PARTITIONS, MOVABLE OFFICE	10
PATIENT MONITORING EQUIPMENT	10
PATIENT ROOM FURNITURE	10
PELVISCOPE	7
PERCUSSOR	5
PERFORATOR	10
PERIPHERAL ANALYZER	10
pH GAS ANALYZER	10
pH METER	10
PHONOCARDIOGRAPH	8
PHOTOCOAGULATOR	10
PHOTOCOPIER	5
PHOTOGRAPHY APPARATUS, GROSS PATHOLOGY	10
PHOTOMETER	8
PHOTOTHERAPY UNIT	10
PHYSICIANS' IN-AND-OUT REGISTER, PORTABLE	10
PHYSIOLOGICAL MONITOR	7
PHYSIOSCOPE	10
PIANO	20
PIPE CUTTER-THREADER	10
PIPETTE, AUTOMATIC	10
PLANER AND SHAPER, ELECTRIC	10
PLASMA FREEZER	10
PLATE-BENDING PRESS	10
PLATELET ROTATOR	20
PLATEMAKER	
COMPUTERIZED	5
NONCOMPUTERIZED	10
POPCORN MACHINE	8
POSITION EMISSION TOMOGRAPHY (PET) SCANNER	5
POWER SUPPLY	10
PRESS, LAUNDRY	15
PRINTING PRESS	10
PROCTOSCOPE	3

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USEFUL LIFE

PROJECTOR	
OVERHEAD	10
SLIDE	10
VIDEO	10
PROTHROMBIN TIMER, AUTOMATED	8
PROTON BEAM ACCELERATOR	7
PULMONARY FUNCTION ANALYZER	8
PULMONARY FUNCTION EQUIPMENT	8
PULSED OXYGEN CHAMBER	10
PULSE OXYMETER	7
PUMP	
BREAST	10
INFUSION	10
STOMACH	10
SUCTION	10
SURGICAL	10
VACUUM	10
RADIATION METER	8
RADIOACTIVE SOURCE, COBALT	5
RADIOGRAPHIC DUPLICATING PRINTER	8
RADIOGRAPHIC-FLUOROSCOPIC COMBINATION	5
RADIOGRAPHIC HEAD UNIT	5
RANGE, DOMESTIC	10
RATE METER, DUAL	10
RECORDER, TAPE	10
REFRACTOMETER	10
REFRIGERATOR	
BLOOD BANK	10
DOMESTIC	10
COMMERCIAL	10
UNDERCOUNTER	10
REMOTE CONTROL RECEIVER	10
RESUSCITATOR	10
RETRACTOR	5
RHINOSCOPE	10
RINSER, SONIC	10
ROTARY TILLER	10
ROTOOSTEOTOME UNIT	10
SAFE 20	
SANITIZER	10

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USEFUL LIFE

SAW	
AUTOPSY	10
BAND	10
BENCH, ELECTRIC	10
MEAT-CUTTING	10
NEUROSURGICAL	10
SURGICAL, ELECTRIC	10
SCAFFOLD	10
SCALE	
BABY	15
BED	10
CHAIR	10
CLINICAL	10
METABOLIC	10
POSTAL	10
SCALE, LAUNDRY	
MOVEABLE	10
PLATFORM	15
SCINTILLATION SCALER	8
SCREEN, PROJECTOR	10
SENSITOMETER	10
SERIOGRAPH, AUTOMATIC	8
SETTEE	12
SEWING MACHINE	15
SHAKING MACHINE (VORTEXER)	8
SHARPENER, MICROTOME KNIFE	10
SHEARS, SQUARING, FLOOR	12
SHELVING, PORTABLE, STEEL	20
SHOULDER WHEEL	20
SIGMOIDOSCOPE	3
SIGNAL-AVERAGE EKG	5
SIMULATOR	5
SINGLE-PHOTON EMISSION COMPUTED TOMOGRAPHY (SPECT) SCANNER	5
SINUSCOPE	7
SKELETON	10
SLICER	
BREAD	10
MEAT	10
SLIDE STAINER, LABORATORY	7
SNOWBLOWER	5
SOFA	12

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USEFUL LIFE

SPECTROPHOTOMETER	8
SPECTROSCOPE	10
SPHYGMOMANOMETER	10
SPIROMETER	8
STALL BARS	15
STAMP MACHINE	10
STAND	
BASIN	15
INTRAVENOUS	15
IRRIGATING	15
MAYO	15
STAPLER, ELECTRIC OR AIR	10
STEAMER, VEGETABLE	10
STEAM-PACK EQUIPMENT	10
STENCIL MACHINE	10
STEREO EQUIPMENT	5
STEREO TACTIC FRAME	5
STERILIZER, MOVABLE	12
STERIS STERILIZATION SYSTEM	7
STETHOSCOPE	5
STRESS TESTER	10
STRETCHER	10
SURGICAL SHAVER	5
TABLE	
ANESTHETIC	15
AUTOPSY	20
ELECTROHYDRAULIC TILT	10
EXAMINING	15
FOLDING	10
FOOD PREPARATION	15
FRACTURE	15
INSTRUMENT	15
LIGHT	15
METAL	15
OBSTETRICAL	20
OPERATING	15
ORTHOPEDIC	10
OVERBED	15
POOL	10
REFRIGERATED	10
THERAPY	15

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TRACTION	10
UROLOGICAL	15
WOOD	15
TANK	
CLEANING	10
FULL-BODY	15
HOT-WATER	10
THERAPY	15
TDX ANALYZER	7
TELEMETRY UNIT	5
TELEPHONE, CORDLESS	5
TELEPHONE EQUIPMENT FOR DEAF	5
TELEPHONE MONITORS	10
TELESCOPE, MICROLENS	10
TELESCOPIC SHOULDER WHEEL	15
TELETHERMOMETER	10
TELEVISION	
MONITOR	5
RECEIVER	5
TENT	
AEROSOL	10
OXYGEN	8
THERMOMETER, ELECTRIC	5
TIME RECORDING EQUIPMENT	10
TISSUE-EMBEDDING CENTER	8
TISSUE PROCESSOR	7
TITRATOR, AUTOMATIC	10
TOASTER, COMMERCIAL	10
TONOMETER	10
TOTALAP	10
TOURNIQUET, AUTOMATIC	10
TOURNIQUET SYSTEM	7
TRACTION UNIT	10
TRACTOR	10
TRANSCRIBING EQUIPMENT	5
TRANSCUTANEOUS NERVE STIMULATOR SYSTEM	5
TRANSESOPHAGEAL TRANSDUCER	5
TREADMILL, ELECTRIC	8

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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

TRUCK (AUTOMOTIVE)	
FORKLIFT	10
MULTIPURPOSE FILLING	15
PICKUP	4
PLATFORM	12
VAN	4
TRUCK (HAND)	
HOT-FOOD	10
TRAY	12
TUBE DRYER	10
TUBE TESTER	5
TUMBLER, LAUNDRY	15
TYPEWRITER	
ELECTRIC	5
MANUAL	5
ULTRASONIC CLEANER	10
ULTRASONIC FETAL HEART MONITOR	7
ULTRASOUND, DIAGNOSTIC	5
ULTRASOUND UNIT, THERAPEUTIC	7
URN, COFFEE	10
VACUUM CLEANER	8
VACUVETTE	10
VALET, OFFICE	15
VEGETABLE PEELER, ELECTRIC	10
VENDING MACHINE	10
VENTILATOR, RESPIRATORY	10
VIAL FILLER	10
VIBRATOR	10
VIDEO	
CAMERA	5
CASSETTE	5
LIGHT SOURCE	5
MONITOR	5
PRINTER	5
WISE, LARGE BENCH	20
WALKIE-TALKIE	5
WARMER	
DISH	10
FOOD	10

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APPENDIX A  
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ESTIMATED USEFUL LIVES OF CAPITAL ASSETS

USEFUL LIFE

WASHING MACHINE	
COMMERCIAL	10
DOMESTIC	8
WATER COOLER, BOTTLE	10
WELDER 10	
WHEELCHAIR	5
WIRE TIGHTENER-TWISTER	10
WORD PROCESSOR	
LARGE	5
SMALL	5
WORK STATION	10
X-RAY EQUIPMENT	
DEVELOPING TANK	10
FILM DRYER	8
FILM PROCESSOR	8
FURNITURE	15
IMAGE INTENSIFIER	5
INTENSIFYING SCREENS	5
SILVER RECOVERY UNIT	7
X-RAY UNIT	
FLUOROSCOPIC	5
MOBILE	5
RADIOGRAPHIC	5
SUPERFICIAL THERAPY	5
WIRING	5

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5101:3-3-71.4      **Intermediate care facilities for the mentally retarded (ICFs-MR): nonreimbursable costs.**

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism, except as specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable costs include but are not limited to:

- (A) Fines or penalties paid under sections 5111.28, 5111.35 to 5111.62, 5111.683 and 5111.99 of the Revised Code.
- (B) Disallowances made during the audit of the ICF-MR's cost report which are sanctioned through adjudication in accordance with Chapter 119. of the Revised Code.
- (C) Costs which exceed prudent buyer tests of reasonableness which may be applied pursuant to the provisions of the provider reimbursement manual (centers for medicare and medicaid services (CMS) Publication 15-1, [www.cms.hhs.gov/manuals](http://www.cms.hhs.gov/manuals)), during the audit of the ICF-MR's cost report.
- (D) The costs of ancillary services rendered to ICF-MR residents by providers who bill medicaid directly. Ancillary services include but are not limited to: physicians, legend drugs, radiology, laboratory, oxygen, and resident-specific medical equipment.
- (E) Cost per case-mix units in excess of the applicable peer group ceiling for direct care cost.
- (F) Expenses in excess of the applicable peer group ceiling for indirect care cost.
- (G) Expenses in excess of the capital costs limitations.
- (H) Expenses associated with lawsuits filed against the Ohio department of job and family services (ODJFS) which are not upheld by the courts.
- (I) Cost of meals sold to visitors or public (i.e., meals on wheels).
- (J) Cost of supplies or services sold to nonfacility residents or public.
- (K) Cost of operating a gift shop.

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Intermediate care facilities for the mentally retarded (ICFs-MR) case mix assessment instrument: individual assessment form (IAF) answer sheet.

(A) All ICFs-MR shall submit to the Ohio department of job and family services (ODJFS) a quarterly case mix assessment, using the JFS 02221 "Individual Assessment Form Answer Sheet" (rev.6/03), for each resident of a medicaid certified ICF-MR bed, regardless of payment source or anticipated length of stay, to reflect the resident's condition on the reporting period end date, which is the last day of the calendar quarter. The ICF-MR shall follow the instructions in the JFS 02220 "Ohio ICF-MR Individual Assessment Form" (rev. 4/07) when completing the JFS 02221.

(1) For purposes of this rule, the following residents shall be considered residents of a medicaid certified bed on the reporting period end date:

(a) Residents admitted to the ICF-MR prior to the reporting period end date and physically residing in the ICF-MR on the reporting period end date; and

(b) Residents admitted to the ICF-MR on the reporting period end date from a non-ICF-MR setting (home, hospital, adult care facility, rest home, nursing facility (NF)); and

(c) Residents transferred or admitted into the ICF-MR from another ICF-MR on the reporting period end date; and

(d) Residents temporarily absent on the reporting period end date but for which the facility is receiving payment, from any source, to hold a bed for the resident during a hospital stay, visit with friends or relatives, or participation in therapeutic programs outside the facility; and

(2) The following residents shall not be considered residents of a medicaid certified bed as of the reporting period end date:

(a) Residents discharged from the ICF-MR prior to or on the reporting period end date; and

(b) Residents transferred to another ICF-MR prior to or on the reporting period end date; and

(c) Residents who die prior to or on the reporting period end date.

(B) ICF-MR providers shall complete and submit a signed JFS 02222 "ICF-MR Certification Form" (rev. 3/07) with the quarterly submission of JFS 02221 data identifying the name of the ICF-MR, its provider number, the total number of beds the provider has certified by the Ohio department of health (ODH) for medicaid, and total number of residents in the ICF-MR as of the reporting period end date for

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whom the provider must submit a JFS 02221 form pursuant to paragraph (A)(1) of this rule.

(C) The JFS 02222 certification form and a copy of the JFS 02221 assessment data forms, in the formats approved by ODJFS, shall be submitted to ODJFS postmarked no later than the fifteenth day of the month following the reporting period end date. The providers shall retain the original JFS 02221 assessment data forms in the resident's record.

(1) If the data is submitted to ODJFS in paper format, the copies of the ODJFS 02221 assessment data forms must be legible and photo-copied single-sided. All of the copies of the JFS 02221 assessment data forms from the same provider number shall be banded together with the provider's JFS 02222 certification form and submitted at the same time in one box or envelope.

(2) If the data is submitted to ODJFS in an electronic format, a paper copy of the JFS 02222 certification form must accompany the electronic data. The electronic data must be submitted in the exact record layout provided in the ODJFS free software. The data in electronic format must be identified with the facility name and medicaid provider number.

(D) Effective December 31, 2007 all ICFs-MR must submit the JFS 02221 assessment data electronically. After that date, ODJFS will not accept JFS 02221 assessment data in a paper format. A paper copy of the JFS 02222 certification form must still accompany the electronic data.

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5101:3-3-73.2 **Resident assessment classification system (RACS): the intermediate care facility for the mentally retarded (ICF-MR) case mix payment system.**

The Ohio department of job and family services (ODJFS) shall pay each eligible ICF-MR a per resident per day rate for direct care costs established prospectively for each facility.

(A) The Ohio medicaid case mix payment system for direct care includes the following components:

- (1) The Ohio ICF-MR JFS 02221 "Individual Assessment Form Answer Sheet" (IAF) (rev. 06/03);
- (2) IAF data elements, as set forth in appendix A and appendix B to this rule, a database which provides the core data elements that are used to group residents into case mix classifications;
- (3) A methodology, set forth in paragraph (C) of this rule, that uses clinically meaningful criteria to group residents into one of four classes;
- (4) The identification of specific job types in the direct care cost category, set forth in paragraph (F) of this rule, that are affected by changes in case mix;
- (5) An assignment of a "relative resource weight", as set forth in paragraph (G) of this rule, that measures the relative costliness of caring for residents in one group versus another.

(B) The ICF-MR case mix payment system shall use the methodology for classifying residents, known as RACS and described in this rule. Residents in each resident assessment class utilize similar quantities and patterns of resources. Based upon the data collected in the IAF, a resident that meets the criteria for placement in more than one class shall be placed in the highest classification according to the hierarchy. The RACS classifications are listed in descending order of the hierarchy. Residents without characteristics resulting in assignment to the higher classifications shall be placed in the fourth classification. The RACS includes the following four mutually exclusive classifications listed in descending order of the hierarchy:

- (1) Chronic medical;
- (2) Overriding behaviors;
- (3) High adaptive needs and/or chronic behaviors; and
- (4) Typical adaptive needs and nonsignificant behaviors.

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(C) The RACS defines the criteria used to assign residents into one of four classifications. The criteria are summarized in paragraphs (C)(1) to (C)(4) of this rule.

(1) The "chronic medical" classification includes residents receiving one or more of the following types of special care:

- (a) Parenteral therapy on all shifts (on the IAF at the medical domain section, item (24) is scored "4").
- (b) Tracheostomy care/suctioning on all shifts (on the IAF, at the medical domain section, item (25) is scored "4").
- (c) Oxygen and respiratory therapy on all shifts (on the IAF at the medical domain section, item (27) is scored "4").
- (d) Oral medication administered more than eight times in a twenty-four-hour day (on the IAF at the medical domain section, item (29a) is scored "3").
- (e) Topical medication administered more than eight times in a twenty-four-hour day (on the IAF at the medical domain section, item (29b) is scored "3").
- (f) Injections of medication administered more than eight times in a twenty-four-hour day (on the IAF at the medical domain section, item (29c) is scored "3").
- (g) Medication administered more than eight times in a twenty-four-hour day using a method other than oral, topical or injection (on the IAF at the medical domain section, item (29d) is scored "3"), and/or
- (h) Utilization of out-of-home health care requiring over thirty days of staff time on average per year (on the IAF at the medical domain section, item (31) is scored "3").

(2) The "overriding behaviors" classification includes residents exhibiting one or more of the following specific behaviors that require continual staff intervention as defined in the JFS 02220:

- (a) Aggressive behavior (on the IAF at the behavior domain section, item (14) is scored "3").
- (b) Self injurious behavior (on the IAF at the behavior domain section, item (17) is scored "3"), and/or

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(c) Acute suicidal behavior (on the IAF at the behavior domain section, item (21) is scored "3").

(3) The "high adaptive needs and/or chronic behaviors" classification includes residents requiring a specific level of staff assistance/supervision for one or more personal care and safety needs as described in paragraphs (C)(3)(a) to (C)(3)(f) of this rule, and/or exhibiting one or more of the behaviors set forth in paragraphs (C)(3)(g) to (C)(3)(j) of this rule that require frequent or continual staff intervention.

(a) Eating (on the IAF at the adaptive skills domain section, item (1) is scored "2" for needing hands-on assistance).

(b) Toileting (on the IAF at the adaptive skills domain section, item (2) is scored either "3" for as a rule does not indicate the need to toilet and requires assistance with wiping, or "4" for requires colostomy, ileostomy, or urinary catheter).

(c) Dressing (on the IAF at the adaptive skills domain section, item (5) is scored "3" for requiring hands-on assistance and/or constant supervision to complete the tasks; or tasks must be done completely by staff for the resident).

(d) Turning and positioning more than twelve times in a twenty-four hour period (on the IAF at the adaptive skills domain section, item (6) is scored "4").

(e) Mobility requiring the help of one or more persons (on the IAF at the adaptive skills domain section, item (7) is scored "3").

(f) Transfer requiring direction and/or physical help from one or more persons (on the IAF at the adaptive skills domain section, item (8) is scored "2").

(g) Aggressive behavior requiring frequent staff intervention as defined in the JFS 02220 (on the IAF at the behavior domain section, item (14) is scored "2").

(h) Self injurious behavior requiring frequent staff intervention as defined in the JFS 02220 (on the IAF at the behavior domain section, item (17) is scored "2").

(i) Disruptive behavior requiring continual staff intervention as defined in the JFS 02220 (on the IAF at the behavior domain section, item (19) is scored "4"), and/or

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- (j) Withdrawn behavior requiring continual staff intervention as defined in the JFS 02220 (on the IAF at the behavior domain section, item (20) is scored "3").
- (4) The "typical adaptive needs and non-significant behaviors" classification includes classifiable residents not meeting the criteria of the other three classifications.
- (D) The IAF data elements, listed by class, used to classify residents in the RACS are set forth in appendix A to this rule. The IAF data elements used by the RACS are listed in numerical order in appendix B to this rule.
- (E) All IAF data elements related to the RACS must be completed before a resident can be classified.
- (F) An analysis of the relationship between resident characteristics and resource utilization, as measured by staff time, identified characteristics differentiating resource use among residents. Staff time and resident assessment data, collected in a work measurement study of Ohio medicaid-certified ICFs-MR for the purpose of establishing common staff times associated with all resident classifications that are standard across residents, staff, facilities, and units, determined that the job classifications listed in paragraphs (F)(1) through (F)(8) of this rule are job types that perform activities that vary by case mix classification. Job types determined not to be positions participating in activities that vary by case mix classification are not included in this rule and are not used to calculate the relative resource weights as described in paragraph (G) of this rule.
- (1) Habilitation specialists consisting of:
- (a) Nurse aides, and
  - (b) Habilitation staff,
- (2) Licensed practical nurses (LPNs).
- (3) Occupational therapists (OTs).
- (4) Program specialists.
- (5) Qualified mental retardation professionals (QMRPs).
- (6) Registered nurses (RNs).
- (7) Social workers/counselors, and
- (8) Speech therapists (STs).

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(G) Each of the four RACS classifications is assigned a relative resource weight. The relative resource weight indicates the relative amount and cost of staff time required on average for the job types listed in paragraph (F) of this rule to deliver care to residents in that RACS class.

(1) Relative resource weights for the four case mix classifications are set forth in appendix C to this rule. The relative resource weight was calculated using the average minutes of care per job type per RACS class as determined during the work measurement study, and the averages of the wages by job type as reported by ICFs-MR on the JFS 02524 "Medicaid ICF-MR Cost Report" (rev. 9/05).

(a) By setting the wage weight at one for the job type receiving the lowest hourly wage, wage weights for the other job types are calculated by dividing the lowest wage into the wage of each of the other job types.

(b) To calculate the total weighted minutes for each RACS class, the wage weight for each job type is multiplied by the average number of minutes members of that job type spend caring for a resident in that RACS class, and the products are summed.

(c) The RACS class with the lowest total weighted minutes receives a relative resource weight of one. Relative resource weights are calculated by dividing the total weighted minutes of the lowest class into the total weighted minutes of each class. Weight calculations are rounded to the fourth decimal place.

(2) Relative resource weights for the four ICF-MR case mix RACS classes are set forth in appendix C to this rule.

(3) As provided in paragraph (G)(3)(a) of this rule, relative resource weights are recalibrated using wage weights based on three-year statewide averages of wages of the job types listed in this rule as reported by ICFs-MR on the JFS 02524, and minutes of care per job type per RACS class as follows:

(a) ODJFS determined the relative resource weights using the minutes of care per job type per RACS class from the most current work measurement study and the wages per job type per hour to be effective for state fiscal year 2008. When recalibrating the relative resource weights, ODJFS used the cost report wage data from calendar years 1998, 1999, and 2000. Relative resource weights for the four case mix classifications are set forth in appendix C to this rule.

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(b) After recalibrating the relative resource weights under paragraph (G)(3)(a) of this rule, ODJFS shall use the recalibrated relative resource weights to calculate the quarterly ICF-MR case mix score for the reporting quarter ending March thirty-first of the calendar quarter preceding the start of the fiscal year and to calculate the annual ICF-MR case mix score for the calendar year preceding the fiscal year.

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APPENDIX A

I. IAF DATA ELEMENTS USED IN THE  
RAC CLASSIFICATION SYSTEM  
by RAC Class

Class #1: Chronic Medical		
ITEM		SCORE
#24	Parenteral Therapy Frequency	#4
#25	Tracheostomy Care/ Suctioning Frequency	#4
#27	Oxygen & Respiratory Therapy Frequency	#4
#29A	Medication Frequency - Oral	#3
#29B	Medication Frequency - Topical	#3
#29C	Medication Frequency - Injection	#3
#29D	Medication Frequency - Other Way	#3
#31	Utilization of Out-of-Home Health Care	#3

Class #2: Overriding Behaviors		
ITEM		SCORE
#14	Aggressive Behavior	#3
#17	Self-injurious Behavior	#3
#21	Suicidal Behavior	#3

Class #3: High Adaptive Needs/Chronic Behaviors		
ITEM		SCORE
# 1	Eating	#2
# 2	Toileting	#3 or #4
# 5	Dressing	#3
# 6	Turning & Positioning	#4
# 7	Mobility	#3
# 8	Transfer	#2
#14	Aggressive Behavior	#2
#17	Self-injurious Behavior	#2
#19	Disruptive Behavior	#4
#20	Withdrawn Behavior	#3

Class #4: Typical Adaptive

All those residents with valid (completed, in range) responses that did not group into Class 1, 2, or 3

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APPENDIX B

II. IAF DATA ELEMENTS USED IN THE  
 RAC CLASSIFICATION SYSTEM  
 by IAF item number

ITEM	SCORE	CLASSIFICATION
<b>ADAPTIVE SKILLS DOMAIN</b>		
# 1 Eating	#2	High Adapt. Needs/Chronic Behav.
# 2 Toileting	#3	High Adapt. Needs/Chronic Behav.
# 2 Toileting	#4	High Adapt. Needs/Chronic Behav.
# 5 Dressing	#3	High Adapt. Needs/Chronic Behav.
# 6 Turning & Positioning	#4	High Adapt. Needs/Chronic Behav.
# 7 Mobility	#3	High Adapt. Needs/Chronic Behav.
# 8 Transfer	#2	High Adapt. Needs/Chronic Behav.
<b>BEHAVIOR DOMAIN</b>		
#14 Aggressive Behavior	#2	High Adapt. Needs/Chronic Behav.
#14 Aggressive Behavior	#3	Overriding Behaviors
#17 Self-injurious Behavior	#2	High Adapt. Needs/Chronic Behav.
#17 Self-injurious Behavior	#3	Overriding Behaviors
#19 Disruptive Behavior	#4	High Adapt. Needs/Chronic Behav.
#20 Withdrawn Behavior	#3	High Adapt. Needs/Chronic Behav.
#21 Suicidal Behavior	#3	Overriding Behaviors
<b>MEDICAL DOMAIN</b>		
#24 Parenteral Therapy Frequency	#4	Chronic Medical
#25 Tracheostomy Care/ Suctioning Frequency	#4	Chronic Medical
#27 Oxygen & Respiratory Therapy Frequency	#4	Chronic Medical
#29A Medication Freq. - Oral	#3	Chronic Medical
#29B Medication Freq. - Topical	#3	Chronic Medical
#29C Medication Freq. - Injection	#3	Chronic Medical
#29D Medication Freq. - Other Way	#3	Chronic Medical
#31 Utilization of Out-of-Home Health Care	#3	Chronic Medical

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APPENDIX C

OHIO MEDICAID ICF-MR  
CASE MIX CLASSIFICATION SYSTEM  
RESIDENT ASSESSMENT CLASSES

RESIDENT ASSESSMENT CLASS	RELATIVE RESOURCE WEIGHT
1. Chronic Medical	2.1762
2. Overriding Behavior	2.0311
3. High Adaptive Needs and/or Chronic Behaviors	1.7274
4. Typical Adaptive Needs and Nonsignificant Behaviors	1.0000

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**Calculation of quarterly and annual intermediate care facility for the mentally retarded (ICF-MR) facility average case mix scores.**

(A) In establishing the direct care component of the intermediate care facility for the mentally retarded rate, the following definitions are used:

(1) "Annual facility average case mix score" is the score used to calculate the facility's cost per case mix unit, and is calculated using the methodology described in paragraph (H) of this rule.

(2) "Case mix reimbursement" is a system that adjusts payment for direct services by identifying resident characteristics associated with actual measured resource use. It takes into account the fact that some residents are more costly to care for than others due to their different care needs.

(3) "Correction submission due date" is the deadline, as set forth in paragraph (F)(3) of this rule, for the ICF-MR to return to the Ohio department of job and family services (ODJFS) the completed "IAF correction document" sent as part of the "IAF Case Mix Initial Quarterly Report". The correction submission due date applies to corrections submitted in electronic format for facility level and resident record changes.

(4) "Critical elements" are data items from a resident's JFS 02221 "Ohio ICF-MR Individual Assessment Form Answer Sheet" (rev. 6/03) that ODJFS verifies prior to determining a resident's class in the resident assessment classification system (RACS).

(5) "Cost per case mix unit" is calculated by dividing the facility's desk reviewed, actual, allowable, per diem direct care costs for the calendar year preceding the fiscal year in which the rate will be paid by the annual facility average case mix score for the calendar year preceding the fiscal year in which the rate will be paid. The lesser of the facility's cost per case mix unit or the maximum allowable cost per case mix unit for the facility's peer group for the fiscal year shall be used to determine the facility's rate for direct care costs, in accordance with rule 5101:3-3-79 of the Administrative Code.

(6) "Direct care peer group" is a group of Ohio medicaid certified ICFs-MR determined by ODJFS to have significant per diem direct care cost differences from the other direct care peer groups due to reasons other than the differences in care needs among the residents. Direct care peer groups are described in rule 5101:3-3-79 of the Administrative Code.

(7) "Facility level errors" are errors described in paragraphs (A)(7)(a) to (A)(7)(c) of this rule and must be corrected before a facility average case mix score can be calculated.

(a) Failure to submit the signed JFS 02222 "ICF-MR Certification of IAF

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Data" (rev. 6/03) form by the correction submission due date.

(b) Incomplete or inaccurate data are submitted to ODJFS on the JFS 02222 form, or, for facilities submitting in electronic format, in the IAF header record.

(c) The number of IAF records processed is more than the reported number of residents in medicaid certified beds on the reporting period end date.

(8) "Filing date" is the deadline for initial quarterly submission of the ICF-MR's IAF data and the JFS 02222, which is the fifteenth calendar day following the reporting period end date. IAF data submission requirements are outlined in rule 5101:3-3-73.1 of the Administrative Code.

(9) "IAF Case Mix Initial Quarterly Report" consists of a report generated by ODJFS and distributed to the ICF-MR on the status of the IAF assessment data which the ICF-MR submitted to ODJFS for the initial quarterly filing. The report contains four components:

(a) "Submission Tracking Summary", which shows the status of the IAF data after initial processing by ODJFS; and

(b) "Detailed Listing of Successfully Grouped Assessments", which is a list of IAF records that were grouped into RACS groups one through four; and

(c) "Correction Document" which is to be used by the ICF-MR to correct errors in the IAF data and is submitted in paper format. The ICF-MR must submit its corrections using a format approved by ODJFS; and

(d) "Deleted/Discharged Assessments" which is a list of resident records being deleted, and/or a list of residents being discharged from the facility.

(10) The JFS 02220 "Ohio ICF-MR Individual Assessment Form" (rev. 11/92) [instructions] is the resident assessment instrument used in the RACS.

(11) The JFS 02221 "Ohio ICF-MR Individual Assessment Form Answer Sheet" provides the resident assessment data which is used to classify the resident into a resident class in the RACS.

(12) "Payment quarter" is two quarters following the reporting quarter and is the quarter following the processing quarter, in which the direct care rate is paid based on the quarterly facility average case mix score from the reporting quarter's IAF data.

(13) "Postmark" means any of the following:

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- (a) The official postmark applied to the package or envelope by the United States postal service; or
- (b) The date the material is received by a commercial delivery service, if marked legibly on the package; or
- (c) If the package or letter is delivered but no date is legible on the package, ODJFS shall consider the postmark to be four calendar days prior to receipt by ODJFS.
- (14) "Processing quarter" is the quarter that follows the reporting quarter and is the quarter in which ODJFS receives the resident assessment data for the reporting quarter and calculates the direct care rate for the payment quarter.
- (15) "Quarterly facility average case mix score" is the facility average case mix score based on data submitted for one reporting quarter and is calculated using the methodology described in paragraph (G) of this rule.
- (16) "Record" means a resident's "Ohio ICF-MR Individual Assessment Form Answer Sheet" (JFS 02221) processed by ODJFS.
- (17) "Relative resource weight" is the measure of the relative costliness of caring for residents in one case mix class versus another, indicating the relative amount and cost of staff time required on average for defined job types to care for residents in a single case mix class. The methodology for calculating relative resource weights is described in rule 5101:3-3-73.2 of the Administrative Code.
- (18) "Reporting period end date" is the last day of each calendar quarter.
- (19) "Reporting quarter" is the quarter which precedes the processing quarter and from which the ICF-MR's resident assessment data are used to establish the direct care rate for the payment quarter.
- (20) "Resident assessment classification system" is the system known as RACS for classifying ICF-MR residents into case mix classes, as outlined in rule 5101:3-3-73.2 of the Administrative Code, and used by ODJFS to gather data for the direct care payment system. The case mix classes are clusters of ICF-MR residents, defined by resident characteristics, that explain resource use.
- (21) "Resident case mix score" is the relative resource weight for the RACS class to which the resident is assigned based on data elements from the resident's IAF assessment.
- (B) ODJFS shall process resident assessment data submitted by ICFs-MR in accordance

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with rule 5101:3-3-73.1 of the Administrative Code and classify residents using the RACS to determine resident case mix scores in accordance with rule 5101:3-3-73.2 of the Administrative Code. These resident case mix scores, based on relative resource weights as set forth in appendix C to rule 5101:3-3-73.2 of the Administrative Code, are used to establish the quarterly facility average case mix score. The methodology for determining the quarterly facility average case mix score is described in paragraph (G) of this rule.

(C) The quarterly facility average case mix score from the reporting quarter is used in conjunction with the lesser of the facility's cost per case mix unit or the maximum allowable cost per case mix unit, adjusted by the inflation rate, to establish the quarterly direct care rate for the payment quarter, as outlined in rule 5101:3-3-79 of the Administrative Code. The facility's cost per case mix unit is calculated using the annual facility average case mix score. The methodology for determining the annual facility average case mix score is described in paragraph (H) of this rule.

(D) ODJFS shall establish each ICF-MR's rate for direct care costs quarterly in accordance with rule 5101:3-3-79 of the Administrative Code. ODJFS shall assign a quarterly facility average case mix score or cost per case mix unit used to establish a facility's rate for direct care costs if the facility fails to submit its resident assessment data in accordance with rule 5101:3-3-73.1 of the Administrative Code or fails to correct facility level errors. Before taking such action ODJFS shall permit the provider a reasonable period of time to correct the information, as described in paragraph (F)(3) of this rule. ODJFS' assignment of the quarterly facility average case mix score or cost per case mix unit will occur as follows:

(1) ODJFS may assign a quarterly facility average case mix score that is five per cent less than the facility's quarterly average case mix score for the preceding calendar quarter instead of using the quarterly average case mix score calculated based on the facility's submitted information as described in paragraph (G) of this rule.

(a) If the facility was subject to an exception review in accordance with rule 5101:3-3-73.4 of the Administrative Code for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than the score determined by the exception review.

(b) If the facility was assigned a quarterly average case mix score for the preceding calendar quarter, the assigned quarterly facility average case mix score shall be the score that is five per cent less than that score assigned for the preceding quarter.

(2) ODJFS may assign a cost per case mix unit that is five per cent less than the provider's calculated or assigned cost per case mix unit for the preceding

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calendar year if the provider has fewer than two acceptable quarterly average case mix scores.

(E) ODJFS shall calculate and use the actual quarterly facility average case mix score described in paragraph (G) of this rule for determining the quarterly direct care rate if:

(1) In accordance with rule 5101:3-3-73.1 of the Administrative Code, the resident assessment information is submitted by the filing date; and includes resident assessments for at least ninety per cent of all residents of medicaid certified ICFs-MR as of the reporting period end date; and

(2) In accordance with the procedures outlined in paragraph (F) of this rule for correcting inaccurate information, the facility's resident assessment information is submitted timely and corrected timely for that reporting quarter; and

(3) The facility's submission of resident assessment data and the JFS 02222 does not contain facility level errors or such errors have been corrected timely, and the facilities submission of any additional IAF data.

(F) After ODJFS has processed the ICF-MR resident assessment data for a reporting quarter, the "Case Mix Provider Summary Report" will be mailed to the ICF-MR. The ICF-MR may correct either ODJFS identified or ICF-MR identified errors or omissions by sending in a modification submission and submitting corrections to ODJFS along with, if necessary, an amended JFS 02222.

(1) ODJFS shall notify ICFs-MR of a missing or incomplete certification form.

(2) ODJFS may notify ICFs-MR of its initial quarterly submission through four documents:

(a) The "Submission Tracking Summary" report.

(b) The "Detailed Listing of Successfully Grouped Assessments" report.

(c) The "Deleted/Discharged Assessments" report.

(d) The "Correction Document".

(3) ODJFS shall allow eighty days after the reporting period end date to make corrections and return them to ODJFS. Timeliness of the submission to ODJFS shall be determined by the postmark.

(4) Corrections received by ODJFS will be used in computing the quarterly facility average case mix score, in accordance with the conditions outlined in paragraph (E) of this rule.

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- (5) ODJFS will process corrections submitted in electronic format if the file format is the same as used by ODJFS.
- (6) Changes made on the "IAF Modification Submission" for IAF data element entries, except for corrections of ODJFS data entry errors, must be consistent with changes made to the original IAF form maintained at the facility.
- (G) The quarterly facility average case mix score for ICFs-MR that submitted their IAF data and modifications timely, and have no facility level errors is calculated as follows:
- (1) All residents' case mix scores for the quarter are added together.
  - (2) The sum of resident case mix scores is divided by the total number of residents.
- (H) The annual facility average case mix score is used to compute the cost per case mix unit for the ICF-MR and the direct care peer group maximum cost per case mix unit. Resident assessment data for all four quarters of the calendar year shall be used to calculate the annual facility average case mix score:
- (1) ODJFS assigned facility average case mix scores will be omitted from the facility's annual average case mix score calculation.
  - (2) The annual facility average case mix score shall be calculated from no fewer than two acceptable quarterly average case mix scores. Acceptable quarterly facility average case mix scores shall be summed and divided by the total number of quarters of acceptable scores. Acceptable quarterly average case mix scores for the purposes of calculating the annual facility average case mix score include, in order of hierarchy:
    - (a) Adjusted quarterly facility average case mix scores as a result of exception review findings, or
    - (b) Quarterly facility average case mix scores calculated based on the facility's submitted information as described in paragraph (G) of this rule.
  - (3) If at least two acceptable quarterly facility average case mix scores are not available ODJFS shall assign the cost per case mix unit, as defined in paragraph (D)(2) of this rule.

5101:3-3-78      **Intermediate care facilities for the mentally retarded (ICFs-MR):  
method for establishing the total prospective rate.**

- (A) The method for establishing the total prospective rate for ICFs-MR is the combination of allowable per diems established for direct care, other protected care, indirect care and capital costs as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and ~~5101:3-3-84~~5101:3-3-84.2 of the Administrative Code. The Ohio department of ~~human services (ODHS)~~ job and family services (ODJFS) shall not reduce the rates calculated pursuant to these rules on the basis that the facility charges a lower rate to any resident who is not eligible for medicaid.
- (B) After ~~ODHS~~ODJFS receives the cost reports for a cost reporting period, ~~ODHS~~ODJFS shall perform a desk review of each cost report. Based on the desk review, ~~ODHS~~ODJFS shall make a preliminary determination whether the costs are allowable. No later than July first of each year, ~~ODHS~~ODJFS shall notify each ICF-MR if any of its costs are preliminarily determined not to be allowable and of its rate calculation and shall explain the reasons for the results. ~~ODHS~~ODJFS shall allow the ICF-MR to verify the calculation and, if necessary, submit additional information.
- (C) ~~ODHS~~ODJFS shall calculate and establish new rates beginning July first of each fiscal year as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and ~~5101:3-3-84~~5101:3-3-84.2 of the Administrative Code. Effective on the first day of each calendar quarter, the direct care per diem of the rate will be adjusted to reflect new assessment information submitted pursuant to rule 5101:3-3-75 of the Administrative Code.

5101:3-3-78      **Intermediate care facilities for the mentally retarded (ICFs-MR):  
method for establishing the total prospective rate.**

- (A) The method for establishing the total prospective rate for ICFs-MR is the combination of allowable per diems established for direct care, other protected care, indirect care and capital costs as set forth in rules 5101:3-3-79, 5101:3-3-82, 5101:3-3-83 and 5101:3-3-84.2 of the Administrative Code. The Ohio department of job and family services (ODJFS) shall not reduce the rates calculated pursuant to these rules on the basis that the facility charges a lower rate to any resident who is not eligible for medicaid.
- (B) After ODJFS receives the cost reports for a cost reporting period, ODJFS shall perform a desk review of each cost report. Based on the desk review, ODJFS shall make a preliminary determination whether the costs are allowable. No later than July first of each year, ODJFS shall notify each ICF-MR if any of its costs are preliminarily determined not to be allowable. ODJFS shall allow the ICF-MR to verify the cost they submitted and, if necessary, submit additional information.

5101:3-3-79     **Method for establishing the direct care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR).**

(A) The Ohio department of job and family services (ODJFS) shall pay each eligible ICF-MR a per resident per day rate for direct care costs established prospectively for each facility. ODJFS shall establish each facility's rate for direct care costs annually.

(B) Each facility's rate for direct care costs shall be based on the facility's cost per case-mix unit (CPCMU), subject to the maximum CPCMU established under paragraph (B)(2) or (B)(3) of this rule, from the calendar year preceding the fiscal year in which the rate is paid. To determine the rate, ODJFS shall:

(1) Determine each facility's CPCMU for the calendar year preceding the fiscal year in which the rate will be paid by dividing the facility's desk-reviewed, actual, allowable, per diem direct care costs for that year by its annual facility average case mix score determined under rule 5101:3-3-73.3 of the Administrative Code for that year.

(2) Set the maximum CPCMU of ICFs-MR with more than eight beds as follows:

(a) ODJFS shall set the maximum CPCMU of ICFs-MR based upon the calendar year preceding the fiscal year in which the rate is paid, as follows:

(i) Calculate the CPCMU under paragraph (B)(1) of this rule from the calendar year preceding the fiscal year in which the rate is paid; and

(ii) Determine each ICF-MR in which the CPCMU has been assigned pursuant to rule 5101:3-3-73.3 of the Administrative Code, any ICF-MR that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid, and any ICF-MR that serves residents who have outlier service needs and for which rates have been set pursuant to rule 5101:3-3-17.5 of the Administrative Code; and

(iii) Array the CPCMUs from the calculation under paragraph (B)(2)(a)(i) of this rule excluding the ICFs-MR determined under paragraph (B)(2)(a)(ii) of this rule in ascending order for each facility and calculate the CPCMU which reflects the median medicaid day; and

(iv) Multiply the median CPCMU obtained under paragraph (B)(2)(a)(iii) of this rule by 1.2246 to obtain the maximum CPCMU.

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- (b) ODJFS shall not recalculate a maximum CPCMUs set under paragraph (B)(2) of this rule based on additional information that ODJFS receives after the maximum CPCMUs is set. ODJFS shall recalculate a maximum CPCMUs only if it made an error in computing the maximum CPCMUs based on the information available at the time of the original calculation.
- (3) Set the maximum CPCMUs of ICFs-MR with eight or fewer beds as follows:
- (a) ODJFS shall set the maximum CPCMUs of ICFs-MR based upon the calendar year preceding the fiscal year in which the rate is paid, as follows:
- (i) Calculate the CPCMUs under paragraph (B)(1) of this rule from the calendar year preceding the fiscal year in which the rate is paid; and
- (ii) Determine each ICF-MR in which the CPCMUs has been assigned pursuant to rule 5101:3-3-73.3 of the Administrative Code. Any ICF-MR that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid, and any ICF-MR that serves residents who have outlier service needs and for which rates have been set pursuant to rule 5101:3-3-17.5 of the Administrative Code; and
- (iii) Array the CPCMUs from the calculation under paragraph (B)(3)(a)(i) of this rule excluding the ICFs-MR determined under paragraph (B)(3)(a)(ii) of this rule in ascending order for each facility and calculate the CPCMUs which reflects the median medicaid day; and
- (iv) Multiply the median CPCMUs obtained under paragraph (B)(3)(a)(iii) of this rule by 1.1880 to obtain the maximum CPCMUs.
- (b) ODJFS shall not recalculate a maximum CPCMUs set under paragraph (B)(3) of this rule based on additional information that ODJFS receives after the maximum CPCMUs is set. ODJFS shall recalculate a maximum CPCMUs only if it made an error in computing the maximum CPCMUs based on the information available at the time of the original calculation.
- (C) Each facility's rate for direct care costs shall be determined annually by multiplying the lesser of the following by the facility average case-mix score, from the quarter ending in March of the preceding fiscal year, determined under rule 5101:3-3-73.3 of the Administrative Code.
- (1) The facility's CPCMUs for the calendar year preceding the fiscal year in which the rate will be paid, as determined under paragraph (B)(1) of this rule; or

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(2) The maximum CPCMUs established for the fiscal year in which the rate will be paid under paragraph (B)(2) or (B)(3) of this rule.

(D) ODJFS shall estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the employment cost index for total compensation, health services component, published by the United States bureau of labor statistics. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, as measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated for the following fiscal year.

(E) For purposes of determining the direct care rate for each facility, the product determined under paragraph (C) of this rule shall be inflated by the inflation rate estimated under paragraph (D) of this rule.

(F) ICFs-MR described under paragraphs (B)(2)(a)(ii) and (B)(3)(a)(ii) of this rule are excluded from the calculation of peer group maximum CPCMUs under paragraph (B) of this rule. The direct care rate for these facilities shall be calculated as follows:

(1) For each ICF-MR in which the CPCMUs has been assigned in accordance with rule 5101:3-3-73.3 of the Administrative Code:

(a) The facility rate for direct care costs shall be determined annually by multiplying the assigned CPCMUs by the facility average case-mix score, from the quarter ending in March of the preceding fiscal year, determined under rule 5101:3-3-73.3 of the Administrative Code; and

(b) The product determined under paragraph (F)(1)(a) of this rule shall be inflated by the inflation rate estimated under paragraph (D) of this rule.

(2) For ICFs-MR or distinct-part units of ICFs-MR that are qualified providers of outlier services, the direct care rate for residents who have received prior authorization from ODJFS to receive outlier services shall be calculated in accordance with rule 5101:3-3-17.5 of the Administrative Code,

(3) For the ICFs-MR described under paragraphs (B)(2)(a)(ii) and (B)(3)(a)(ii) of this rule that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid, reimbursement shall be made in accordance with rules 5101:3-3-86 and 5101:3-3-86.1 of the Administrative Code.

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**Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners, and administrators in intermediate care facilities for the mentally retarded (ICFs-MR).**

Compensation costs for owners, relatives of owners, and administrators are subject to compensation cost limits. Determining reasonable cost for compensation and compensation disallowances for owners, relatives of owners, and administrators is comprised of two components:

(A) Compensation cost limits for owners, relatives of owners, and administrators.

(1) Compensation cost limits as adjusted for owners and relatives of owners is the maximum compensation cost limit calculated for owners and relatives of owners under paragraphs (A) and (B) of rule 5101:3-3-81.1 of the Administrative Code.

(2) Compensation cost limits for administrators is the maximum compensation cost limit calculated for administrators under paragraph (A) of rule 5101:3-3-81.2 of the Administrative Code.

(B) Reasonable costs for compensation and compensation disallowances if any for owners and relatives of owners, and administrators are subject to compensation cost limits.

(1) Reasonable costs for compensation and compensation disallowances if any for owners and relatives of owners are the facility's desk reviewed, actual, allowable costs reported on schedule C-2 of the JFS 02524 "Ohio department of job and family services medicaid ICF-MR cost report" (Rev. 01/2007) subject to the applicable compensation cost limits as adjusted under paragraph (C) of rule 5101:3-3-81.1 of the Administrative Code and audited by the Ohio department of job and family services (ODJFS).

(2) Reasonable costs for compensation and compensation disallowance if any for administrators are the facility's desk reviewed, actual, allowable costs reported on schedule C-1 of the JFS 02524 medicaid cost report subject to the applicable compensation cost limits as adjusted under paragraph (B) of rule 5101:3-3-81.2 of the Administrative Code and audited by ODJFS.

5101:3-3-81.1**Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for owners, relatives of owners in intermediate care facilities for the mentally retarded (ICFs-MR).**

The purpose of this rule is to establish applicable compensation cost limits, the reasonable compensation, and compensation disallowances if any for owners and relatives of owners working in ICFs-MR. Paragraph (A) of this rule establishes the annual compensation cost limits for owners and relatives of owners working in positions listed on attachment 6 of the JFS 02524 "Ohio department of job and family services medicaid ICF-MR cost report" (Rev. 01/2007). The positions listed on attachment 6 of the JFS 02524 medicaid cost report are for individuals working only in one facility for twelve consecutive months at forty hours per week. Paragraph (B) of this rule establishes the compensation cost limits for owners and relatives of owners working in the following corporate positions; corporate president, corporate vice-president, corporate treasurer, and board secretary/member and work in only one facility, twelve consecutive months and for forty hours per week. Paragraph (C) of this rule calculates the reasonable compensation and compensation disallowance if any for each owner and relative of owner who's compensation costs exceeds the applicable compensation cost limit, as determined under paragraph (A) or (B) of this rule, adjusted for days worked in a calendar year and the percentage of time worked. Paragraph (C) uses a "time slice" methodology to identify reported compensation and hours for each owner or relative of an owner working in a facility and related facilities if any. Time slices are subsequently used to determine the appropriate compensation cost limits, reasonable compensation costs, and compensation disallowances for each owner and relative of an owner.

(A) Compensation cost limits for owners and relatives of owners shall be based upon compensation costs for individuals who hold comparable positions but who are not owners or relatives of owners, as reported on the JFS 02524 from the calendar year preceding the fiscal year in which the rate is paid. As used in this rule, "comparable position" means the position that is held by the owner or owner's relative, if that position is listed separately on the JFS 02524, or if the position is not listed separately, the group of positions that is listed on the cost report form and that includes the position held by the owner or the owner's relative. The compensation cost limit for owners and relatives of owners who function in positions listed on attachment 6 of the JFS 02524 shall be based upon the wage and hour equivalents which are calculated as follows:

(1) The compensation cost limits for owners and relatives of owners are calculated from the following JFS 02524 excluding cost reports for providers of outlier services as specified in rule 5101:3-3-17.5 of the Administrative Code:

(a) Cost reports for ICFs-MR with a December thirty-first end date; and

(b) Desk reviewed and preliminarily determined to be allowable costs for ICFs-MR.

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(2) For each wage and hour chart of account number from attachment 6 of the JFS 02524, calculate the compensation cost limits as follows:

(a) Calculate the total non-owner wages paid by summing the total non-owner wages paid (Col E) for all providers that have amounts reported in columns (E) and (H) of attachment 6 of the JFS 02524.

(b) Calculate the total non-owner hours paid by summing the total non-owner hours paid (Col H) for all providers that have amounts reported in columns (E) and (H) of attachment 6 of the JFS 02524.

(c) Calculate the average hourly rate by dividing the total non-owner wages paid as calculated under paragraph (A)(2)(a) of this rule by the total non-owner hours paid as calculated under paragraph (A)(2)(b) of this rule.

(d) Calculate the compensation cost limit by multiplying the average hourly rate as calculated under paragraph (A)(2)(c) of this rule by two thousand eighty hours.

(B) Compensation cost limits for an owner or an owner's relative who serves the ICF-MR in a capacity such as corporate officer, for which no comparable position or group of positions is listed on attachment 6 of the JFS 02524 shall be based upon the civil service equivalents. Compensation for owners and relatives of owners that are corporate officers is allowable for managerial, administrative, professional and other services related to the operation of the facility and rendered in connection with patient care. The compensation cost limit for owners and relatives of owners who function in corporate positions shall be based upon the civil service equivalents as listed below and in the case of a proprietor or a partner, one of the below listed civil service equivalents shall be applied based upon the duties performed:

(1) Corporate president

(a) Business administrator 3, class number 63317 for facilities with a combined bed total of one to ninety-nine; or

(b) Business administrator 4, class number 63318 for facilities with a combined bed total of one hundred to one hundred ninety-nine; or

(c) Business administrator 5, class number 63319 for facilities with a combined bed total of two hundred to two hundred ninety-nine; or

(d) Director 1, class number 61111 for facilities with a combined bed total of three hundred to five hundred ninety-nine; or

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(e) Director 2, class number 61112 for facilities with a combined bed total of six hundred to one thousand one hundred ninety-nine; or

(f) Director 3, class number 61113 for facilities with a combined bed total of one thousand two hundred or more.

(2) Corporate vice-president

(a) Administrative assistant 3, class number 63123 for facilities with a combined bed total of one to ninety-nine; or

(b) Administrative assistant 4, class number 63124 for facilities with a combined bed total of one hundred to one hundred ninety-nine; or

(c) Assistant director 1, class number 61211 for facilities with a combined bed total of two hundred to two hundred ninety-nine; or

(d) Assistant director 2, class number 61212 for facilities with a combined bed total of three hundred to five hundred ninety-nine; or

(e) Assistant director 3, class number 61213 for facilities with a combined bed total of six hundred to one thousand one hundred ninety-nine; or

(f) Assistant director 4, class number 61214 for facilities with a combined bed total of one thousand two hundred or more.

(3) Corporate treasurer

(a) Fiscal specialist 1, class number 66531 for facilities with a combined bed total of one to ninety-nine; or

(b) Fiscal specialist 2, class number 66532 for facilities with a combined bed total of one hundred to one hundred ninety-nine; or

(c) Fiscal officer 1, class number 66535 for facilities with a combined bed total of two hundred to two hundred ninety-nine; or

(d) Fiscal officer 2, class number 66536 for facilities with a combined bed total of three hundred to five hundred ninety-nine; or

(e) Fiscal officer 3, class number 66537 for facilities with a combined bed total of six hundred to one thousand one hundred ninety-nine; or

(f) Fiscal officer 4, class number 66538 for facilities with a combined bed total of one thousand two hundred or more.

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(4) Board secretary/member

- (a) Secretary, class number 12551 for facilities with a combined bed total of one to ninety-nine; or
- (b) Office manager, class number 16821 for facilities with a combined bed total of one hundred to one hundred ninety-nine; or
- (c) Executive secretary 1, class number 16832 for facilities with a combined bed total of two hundred to two hundred ninety-nine; or
- (d) Administrative assistant 3, class number 63123 for facilities with a combined bed total of three hundred to five hundred ninety-nine; or
- (e) Board secretary 1, class number 62111 for facilities with a combined bed total of six hundred to one thousand one hundred ninety-nine; or
- (f) Board secretary 2, class number 62112 for facilities with a combined bed total of one thousand two hundred or more.

(5) For those owners and relatives of owners who serve the ICF-MR in the capacity of a corporate officer, proprietor or partner as specified under paragraphs (B)(1) to (B)(4) of this rule, the formula for determining the compensation cost limits is as follows:

- (a) The civil service equivalent hourly rate as published by the Ohio department of administrative services for those positions specified under paragraphs (B)(1) to (B)(4) of this rule will be multiplied by two thousand eighty hours to arrive at an annual salary screen for each step in the position. If the civil service equivalent hourly rate changes during the reporting period, the civil service equivalent hourly rate will be the hourly rate that is in effect at the end of the cost reporting period.
- (b) The appropriate job step within those civil service classifications as specified under paragraphs (B)(1) to (B)(4) of this rule will be based upon the owner's years of service in the health care field plus one.

(C) Reasonable costs for compensation and compensation disallowances for owners and relatives of owners are the facility's desk reviewed, actual, allowable costs reported on schedule C-2 of the JFS 02524 subject to the applicable compensation cost limits and audit by ODJFS. For each owner or relative of an owner that has reported compensation on schedule C-2 of the JFS 02524 shall perform the following steps.

(1) An owner and relative of an owner time slice is defined as follows:

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- (a) The number of days employed except when there is an overlap of an employment period for an owner or relative of an owner working in a related facility and the functions have the same position number; or
- (b) When there is an overlap of an employment period for an owner or relative of an owner working in a related facility and the functions have the same position number, the number of days within an owner or relative of an owner compensation time slice for the individual is:
  - (i) The number of days employed for the overlap of an employment period when the individual is working in the related facility during the same period of time.
  - (ii) The number of days employed for the overlap of an employment period when the individual is working in the related facility during the same period of time.
  - (iii) The number of days employed subsequent to the overlapping employment period.

(2) For each owner and relative of an owner compensation time slice, calculate the following:

- (a) Acquire the number of certified beds for the facility as of the end of the cost reporting period from schedule A, line 2, column 1 of the JFS 02524; and
- (b) Acquire the number of certified beds from the JFS 02524 for related facilities, as of the end of the cost reporting period; and
- (c) Calculate the total number of certified beds by adding the number of certified beds for the facility as determined under paragraph (C)(2)(a) of this rule and the number of certified beds for any related facilities as determined under paragraph (C)(2)(b) of this rule.
- (d) For owners and relatives of owners who received compensation as a corporate officer, acquire the appropriate corporate duty job step as calculated under paragraph (B)(5)(b) of this rule; and
- (e) Determine the applicable compensation cost limit based on the position the owner or relative of an owner worked as follows:
  - (i) For owners and relatives of owners that are performing duties that are included on attachment 6 of the JFS 02524 acquire the appropriate compensation cost limit as calculated under paragraph (A)(2)(d) of this rule subject to the following criteria:

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- (a) Compensation is allowable only for duties performed by owners which otherwise would require the employment of another individual.
- (b) In order to qualify as a supervisor for positions listed on attachment 6 of the JFS 02524, the supervisor must supervise at least two individuals in facilities with fifty beds or more. In facilities with less than fifty beds, a supervisor may supervise one individual; or

  - (ii) For owners and relatives of owners who performed duties which otherwise would have required the employment of another individual and received compensation as a corporate officer, acquire the appropriate compensation cost limit as calculated under paragraph (B)(5) of this rule; and
  - (iii) For purposes of determining the compensation cost limits, owners and relatives of owners, are overtime exempt. There shall be no upward adjustment to the applicable compensation cost limit to accommodate circumstances where such individuals work in excess of forty hours per week.
- (f) Calculate the number of days in the time slice for each individual by subtracting the beginning date from the ending date for each time slice and adding one; and
- (g) Determine the total days in the calendar year; and
- (h) Calculate the per cent of days allowed by dividing the number of days in the time slice as calculated under paragraph (C)(2)(f) of this rule by the total days in the calendar year as determined under paragraph (C)(2)(g) of this rule; and
- (i) Calculate the time slice adjusted compensation cost limit by multiplying the per cent of days allowed as calculated under paragraph (C)(2)(h) of this rule by the adjusted compensation as calculated under paragraph (C)(2)(e) of this rule.
- (j) Acquire the weekly hours in the time slice for the appropriate time period from schedule C-2 of the JFS 02524; and
- (k) Acquire the related weekly hours in the time slice for the appropriate time period from the related facilities' schedule C-2 of the JFS 02524; and
- (l) Calculate the total weekly hours in the time slice by adding the weekly hours in the time slice as determined under paragraph (C)(2)(j) of this

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rule and the related weekly hours in the time slice as determined under paragraph(C)(2)(k) of this rule; and

(m) Calculate the maximum weekly hours:

(i) If the total weekly hours in the time slice as calculated under paragraph (C)(2)(l) of this rule is less than thirty-five hours per week then the maximum weekly hours in the time slice is forty; or

(ii) If the total weekly hours in the time slice as calculated under paragraph (C)(2)(l) of this rule is greater than or equal to thirty-five hours per week then the maximum weekly hours in the time slice is the total weekly hours in the time slice; and

(n) Calculate the hours allocation percentage by dividing the weekly hours in the time slice as calculated under paragraph (C)(2)(j) of this rule by the maximum weekly hours as calculated under paragraph (C)(2)(m) of this rule; and

(o) Calculate the final time slice adjusted compensation cost limit by multiplying the time slice adjusted compensation cost limit as calculated under paragraph (C)(2)(i) of this rule by the hours allocation percentage as calculated under paragraph (C)(2)(n) of this rule.

(p) Calculate a daily salary amount for each owner and relative of an owner by dividing the compensation amount by the number of days employed as reported on schedule C-2 of the JFS 02524. For each time slice, calculate the prorated owner and relative of an owner compensation amount by multiplying the daily salary amount for each owner and relative of an owner by the number of days in the time slice as calculated under paragraph (C)(2)(f) of this rule.

(q) Calculate the owner and relative of an owner compensation disallowance amount by subtracting the final time slice adjusted compensation cost limit as calculated under paragraph (C)(2)(o) of this rule from the prorated owner and relative of an owner compensation amount as calculated under paragraph (C)(2)(p) of this rule. The result cannot be less than zero.

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**Compensation cost limits, reasonable costs for compensation, and compensation disallowances if any for administrators in intermediate care facilities for the mentally retarded (ICFs-MR).**

The purpose of this rule is to establish applicable compensation cost limits, the reasonable cost for compensation and compensation disallowances, and costs for duties that may be reported in the direct care cost center for administrators working in ICFs-MR. Paragraph (A) of this rule establishes the annual compensation cost limits for administrators. The compensation cost limit assumes that an administrator worked only in one facility for twelve consecutive months at forty hours per week. Paragraph (B) of this rule uses a "time slice" methodology to identify the hours an administrator works in a facility and related facilities. Time slices are subsequently used to determine the administrator coverage and appropriate compensation cost limits and reasonable compensation cost for each administrator. Paragraph (B)(1) of this rule establishes the coverage requirements, for ICFs-MR licensed by the Ohio department of health (ODH), depending on the ICF-MR's bed size and any applicable disallowance for a facility not maintaining the appropriate administrator coverage. Paragraph (B)(2) of this rule calculates the reasonable cost for compensation and compensation disallowance if any for each administrator who's compensation costs exceeds the applicable compensation cost limit, as determined under paragraphs (A) and (B) of this rule, adjusted for days worked in a calendar year and the percentage of time worked. Paragraph (B)(3) of this rule calculates a disallowance for a facility paying more than the cost of one full time administrator for the period. Paragraph (C) of this rule specifies direct care duties and associated costs that an administrator may report under the direct care cost center. The direct care costs reported by the administrator are not subject to the compensation cost limit.

(A) Compensation cost limits for administrators shall be based upon compensation costs for administrators who are non-owners or relatives of owners, as reported on the JFS 02524 Ohio department of job and family services medicaid ICF-MR cost report (Rev. 01/2007) from the calendar preceding the fiscal year in which the rate is paid. The compensation cost limits for administrators excluding owners or relatives of owners who are administrators are calculated as follows:

(1) The compensation cost limits for administrators are calculated from the following JFS 02524 excluding cost reports for providers of outlier services as specified in rules 5101:3-3-17.5 and 5101:3-3-17.4 of the Administrative Code:

(a) Cost reports for ICFs-MR with a December thirty-first end date; and

(b) Desk reviewed and preliminarily determined to be allowable costs for ICFs-MR.

(2) For each individual non-owner administrator, calculate the hourly rate from the JFS 02524 schedule C-1 as follows:

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- (a) Calculate the number of days employed by subtracting the employment period beginning date from the employment period ending date. Add one day to the number of days calculated to account for total days worked as reported on the cost report; and
  - (b) Calculate the number of weeks worked by dividing the number of days employed by seven as calculated under paragraph (A)(2)(a) of this rule; and
  - (c) Calculate the weekly compensation amount by dividing the compensation amount as reported on the cost report by the number of weeks worked as calculated under paragraph (A)(2)(b) of this rule; and
  - (d) Calculate the hourly rate by dividing the weekly compensation amount as calculated under paragraph (A)(2)(c) of this rule by the weekly hours as reported on the cost report.
- (3) Exclude any administrator's hourly rate as calculated under paragraph (A)(2) of this rule that is less than the federal minimum wage rate in effect at the end of the cost reporting period.
- (4) Excluding administrators as determined in paragraph (A)(3) of this rule, calculate the average annual facility administrator salary for each facility from the JFS 02524 schedule C-1 as follows:
- (a) For each administrator calculate the hours worked by multiplying the weekly hours as reported on the cost report by the number of days employed as calculated under paragraph (A)(2)(a) of this rule; and
  - (b) For all administrators as reported for each facility total the following:
    - (i) Number of days employed as calculated under paragraph (A)(2)(a) of this rule; and
    - (ii) Compensation amounts as reported on the cost report; and
    - (iii) Hours worked as calculated under paragraph (A)(4)(a) of this rule; and
  - (c) Calculate a weighted facility average weekly hours by dividing the sum of the weighted weekly hours as calculated under paragraph (A)(4)(b)(iii) of this rule by the total number of days employed as calculated under paragraph (A)(4)(b)(i) of this rule; and
  - (d) Calculate the weighted facility compensation amount:

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(1) The administrator coverage disallowance amount applies to ICFs-MR licensed by the ODH. For each individual administrator's weekly hours reported on schedule C-1 of the JFS 02524 perform the following steps to determine the administrator coverage disallowance amount:

(a) General parameters.

(i) Facilities with a licensed bed capacity greater than ninety-nine are required to have at least thirty weekly hours of combined administrator coverage reported on schedule C-1 of the JFS 02524. The facility may employ more than one administrator to meet the minimum administrator coverage requirement. At least fifteen hours of the administrator's time must be spent at the facility between the hours of six a.m. and six p.m. Monday through Friday.

(ii) Facilities with a licensed bed capacity of ninety-nine or less are required to have at least sixteen weekly hours of combined administrator coverage reported on schedule C-1 of the JFS 02524. The facility may employ more than one administrator to meet the minimum administrator coverage requirement. At least eight hours of the administrator's time must be spent at the facility between the hours of six a.m. and six p.m. Monday through Friday.

(iii) In the event that a facility of one-hundred beds or more has a loss of an administrator, ODJFS will automatically waive the thirty-hour per week minimum administrator coverage requirement for up to a maximum of sixty calendar days per calendar year. ODJFS may waive the thirty-hour per week minimum administrator coverage requirement for longer than sixty days per calendar year if the facility demonstrates that it has been unable to hire an administrator despite diligent recruiting efforts. During any time period when the thirty-hour per week minimum administrator coverage requirement is waived, the sixteen hours per week minimum administrator coverage requirement of the ODH must still be met.

(iv) A facility may hold more than one medicaid provider agreement within the same physical structure. For these type facilities, without regard for provider number distribution, total the number of certified beds in the ICF-MR, then total the number of hours worked by the administrator(s) in the ICF-MR, to determine if the minimum administrator coverage requirement under paragraph (B)(1)(a) of this rule is met.

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(b) Calculate the number of calendar days where the minimum administrator coverage requirement under paragraph (B)(1)(a) of this rule was not met by using the weekly hours as reported on schedule C-1 of the JFS 02524 and the employment period for each individual administrator as reported on schedule C-1 of the JFS 02524. Sum each administrator's weekly hours for each calendar day of the cost reporting period. Determine each calendar day of the cost reporting period that does not meet the minimum administrator coverage requirement under paragraph (B)(1)(a) of this rule and total the number of calendar days that do not meet the minimum administrator coverage requirement.

(c) For each administrator reported on schedule C-1 of the JFS 02524 perform the following steps to determine the administrator coverage disallowance amount for not meeting the minimum administrator coverage requirements under paragraph (B)(1) of this rule:

(i) A minimum administrator coverage requirement time slice is defined as follows:

(a) The number of days employed except when there is an overlap of employment periods for administrators within the same facility; or

(b) When there is an overlap of employment periods for administrators within the same facility, the number of days within a time slice for each administrator is:

(i) The number of days employed for the overlap of an employment period when the administrators are working in the same facility during the same period of time.

(ii) The number of days employed preceding the overlapping employment period.

(iii) The number of days employed subsequent to the overlapping employment period.

(ii) For each minimum administrator coverage requirement time slice, calculate the following:

(a) Acquire the number of certified beds for the facility as of the end of the cost reporting period from schedule A, line 2, column 1 of the JFS 02524; and

(b) Calculate the total number of days employed for each

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administrator by subtracting the beginning date from the ending date for each time slice and adding one; and

(c) Calculate the total number of days employed where the minimum administrator coverage requirement under paragraph (B)(1)(b) of this rule was not met; and

(d) Calculate the total number of waived days that are automatically provided under paragraph (B)(1)(a)(iii) of this rule that are applicable to each time slice; and

(e) Calculate the total number of additional waived days as determined under paragraph (B)(1)(a)(iii) of this rule that are applicable to the time slice period; and

(f) Calculate the total number of non-waived days by subtracting the waived days as calculated under paragraphs (B)(1)(c)(ii)(d) and (B)(1)(c)(ii)(e) of this rule from the total number of days employed within the time slice where the minimum administrator coverage requirement were not met under paragraph (B)(1)(c)(ii)(c) of this rule; and

(g) Calculate the percentage of time without minimum administrator coverage requirement by dividing the total number of non-waived days as calculated under paragraph (B)(1)(c)(ii)(f) of this rule by the number of days employed within a time slice as calculated under paragraph (B)(1)(c)(ii)(b) of this rule; and

(h) Calculate a daily salary amount for each administrator by dividing the compensation amount by the number of days employed as reported on schedule C-1 of the JFS 02524. For each time slice, calculate the prorated administrator compensation amount by multiplying the daily salary amount for each administrator by the number of days employed in each time slice as calculated under paragraph (B)(1)(c)(ii)(b) of this rule; and

(i) Calculate the administrator coverage disallowance amount by multiplying the prorated administrator compensation amount calculated under paragraph (B)(1)(c)(ii)(h) of this rule by the percentage of time without minimum administrator coverage requirement as calculated under paragraph (B)(1)(c)(ii)(g) of this rule.

(2) Reasonable costs for compensation and compensation disallowances for administrators are the facility's desk reviewed, actual, allowable costs

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reported on schedule C-1 of the JFS 02524 subject to the applicable compensation cost limits and audit by ODJFS. For each individual administrator compensation reported on schedule C-1 of the JFS 02524 perform the following steps:

(a) An individual administrator compensation time slice is defined as follows:

(i) The number of days employed except when there is an overlap of an employment period for an administrator working in a related facility; or

(ii) When there is an overlap of an employment period for an administrator working in a related facility, the number of days within an individual administrator compensation time slice for the administrator is:

(a) The number of days employed for the overlap of an employment period when the administrator is working in the related facility during the same period of time.

(b) The number of days employed preceding the overlapping employment period.

(c) The number of days employed subsequent to the overlapping employment period.

(b) For each individual administrator compensation time slice, calculate the following:

(i) Acquire the number of certified beds for the facility as of the end of the cost reporting period from schedule A, line 2, column 1 of the JFS 02524; and

(ii) Acquire the number of certified beds for related facilities that the administrator worked in, during the individual administrator compensation time slice, as of the end of the cost reporting period from schedule A, line 2, column 1 of the JFS 02524; and

(iii) Calculate the total number of certified beds by adding the number of certified beds for the facility as determined under paragraph (B)(2)(b)(i) of this rule and the number of certified beds for any related facilities that the administrator worked in determined under paragraph (B)(2)(b)(ii) of this rule; and

(iv) Acquire the appropriate compensation cost limit as follows:

(a) If the administrator does not work in four or more related

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facilities, use the total number of certified beds determined under paragraph (B)(2)(b)(iii) of this rule to determine the appropriate compensation cost limit determined under paragraph (A)(6) of this rule; or

(b) If the administrator works in four or more related facilities, the compensation cost limit is the maximum for the bed size category determined under paragraph (A)(6) of this rule; and

(v) Acquire the allowance percentage from schedule C-1 of the JFS 02524 which shall not exceed one hundred-fifty per cent; and

(vi) Calculate the adjusted compensation cost limit by multiplying the compensation cost limit determined under paragraph (B)(2)(b)(iv) of this rule by the allowance percentage determined under paragraph (B)(2)(b)(v) of this rule; and

(vii) Calculate the total number of days employed for each administrator by subtracting the beginning date from the ending date for each time slice and adding one; and

(viii) Determine the total days in the calendar year; and

(ix) Calculate the per cent of days allowed by dividing the number of days in the individual administrator compensation time slice as calculated under paragraph (B)(2)(b)(vii) of this rule by the total days in the calendar year as determined under paragraph (B)(2)(b)(viii) of this rule; and

(x) Calculate the time slice adjusted compensation cost limit by multiplying the per cent of days allowed as calculated under paragraph (B)(2)(b)(ix) of this rule by the adjusted compensation as calculated under paragraph (B)(2)(b)(vi) of this rule; and

(xi) Acquire the weekly hours in the individual administrator compensation time slice for the appropriate time period from schedule C-1 of the JFS 02524; and

(xii) Acquire the related weekly hours in the individual administrator compensation time slice for the appropriate time period from the related facilities' schedule C-1 of the JFS 02524; and

(xiii) Calculate the total weekly hours in the individual administrator compensation time slice by adding the weekly hours in the individual administrator compensation time slice as determined under paragraph (B)(2)(b)(xi) of this rule and the related weekly

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hours in the individual administrator compensation time slice as determined under paragraph (B)(2)(b)(xii) of this rule; and

(xiv) Calculate the maximum weekly hours:

(a) If the total weekly hours in the individual administrator compensation time slice as calculated under paragraph (B)(2)(b)(xiii) of this rule is less than thirty-five hours per week then the maximum weekly hours in the individual administrator compensation time slice is forty; or

(b) If the total weekly hours in the individual administrator compensation time slice as calculated under paragraph (B)(2)(b)(xiii) of this rule is greater than or equal to thirty-five hours per week then the maximum weekly hours in the individual administrator compensation time slice is the total weekly hours in the individual administrator compensation time slice; and

(xv) Calculate the hours allocation percentage by dividing weekly hours in the individual administrator compensation time slice as calculated under paragraph (B)(2)(b)(xi) of this rule by the maximum weekly hours as calculated under paragraph (B)(2)(b)(xiv) of this rule; and

(xvi) Calculate the final time slice adjusted compensation cost limit by multiplying the time slice adjusted compensation cost limit as calculated under paragraph (B)(2)(b)(x) of this rule by the hours allocation percentage as calculated under paragraph (B)(2)(b)(xv) of this rule; and

(xvii) Calculate a daily salary amount for each administrator by dividing the compensation amount by the number of days employed as reported on schedule C-1 of the JFS 02524. For each time slice, calculate the prorated administrator compensation amount by multiplying the daily salary amount for each administrator by the number of days employed in each time slice as calculated under paragraph (B)(2)(b)(vii) of this rule; and

(xviii) Acquire the administrator coverage disallowance amount applicable to this time slice as calculated under paragraph (B)(1)(c)(ii)(h) of this rule; and

(xix) Calculate the adjusted prorated administrator compensation amount by subtracting the administrator coverage disallowance amount as calculated under paragraph (B)(2)(b)(xviii) of this rule from the prorated administrator compensation amount as

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calculated under paragraph (B)(2)(b)(xvii) of this rule; and

(xx) Calculate the individual administrator compensation disallowance by subtracting the final time slice adjusted compensation cost limit as calculated under paragraph (B)(2)(b)(xvi) of this rule from the adjusted prorated administrator compensation amount as calculated under paragraph (B)(2)(b)(xix) of this rule. The result cannot be less than zero.

(xxi) Calculate the final adjusted prorated administrator compensation amount by subtracting the individual administrator compensation disallowance as calculated under paragraph (B)(2)(b)(xx) of this rule from the adjusted prorated administrator compensation amount as calculated under paragraph (B)(2)(b)(xix) of this rule.

(3) For each ICF-MR, determine the overall facility administrator aggregate compensation disallowance for reporting costs in excess of the adjusted compensation cost limit as follows:

(a) Acquire the number of certified beds for the facility as of the end of the cost reporting period from schedule A, line 2, column 1 of the JFS 02524; and

(b) Acquire the appropriate compensation cost limit for the bed size category using the total number of certified beds determined under paragraph (B)(3)(a) of this rule and the compensation cost limit determined under paragraph (A)(6) of this rule; and

(c) Establish the allowance percentage as one hundred-fifty per cent; and

(d) Calculate the adjusted compensation cost limit by multiplying the compensation cost limit determined under paragraph (B)(3)(b) of this rule by the allowance percentage determined under paragraph (B)(3)(c) of this rule; and

(e) Calculate the total administrator allowable compensation by summing the compensation reported on schedule C-1 of the JFS 02524 for all administrators and subtracting any disallowances calculated under paragraphs (B)(1)(c)(ii)(i) and (B)(2)(b)(xx) of this rule; and

(f) Calculate the overall facility administrator aggregate compensation disallowance by subtracting the adjusted compensation cost limit as calculated under paragraph (B)(3)(d) of this rule from the total administrator allowable compensation as calculated under paragraph (B)(3)(e) of this rule. The result cannot be less than zero.

(C) If an administrator works in one or more of the following direct care cost center

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positions, the compensation earned for performing such duties may be expensed directly to the direct care cost center. Compensation for an administrator performing a direct care cost center function is allowable only for duties which otherwise would require the employment of another individual. The portion of the individual's total compensation paid by the ICF-MR that may be reported in the direct care cost center shall be determined by multiplying the total compensation by the percentage of time the individual spends performing the direct care duties. The ICF-MR must maintain records documenting the allocation of the individual's time to these duties. Time studies conducted in accordance with the health care financing administration (HCFA) publication 15-1 (09/08/2005) shall be considered sufficient documentation of the allocation of time. If it is found that the ICF-MR has not sufficiently documented the allocation of time, the cost associated with the undocumented time will be reclassified back to the indirect cost center. Those direct care cost center functions are:

- (1) Medical director;
- (2) Director of nursing;
- (3) Activities director;
- (4) Registered nurse (RN);
- (5) Licensed practical nurse (LPN);
- (6) Recreational therapist;
- (7) Psychologist;
- (8) Respiratory therapist;
- (9) Qualified mental retardation professional (QMRP);
- (10) Licensed social worker/counselor;
- (11) Chaplain;
- (12) Charge nurse registered nurse;
- (13) Charge nurse licensed practical nurse.

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**Intermediate care facilities for the mentally retarded (ICFs-MR): method for establishing the other protected costs component of the prospective rate.**

- (A) The Ohio department of job and family services (ODJFS) shall pay each eligible ICF-MR a per diem for each resident for other protected costs. This component of the rate will be established prospectively each fiscal year for each facility. This per diem shall be calculated by taking the desk-reviewed, actual, allowable other protected costs total except for the franchise permit fee (account number 6091) and dividing by the inpatient days. This information will come from the year ending cost report preceding the fiscal year in which the rate will be paid. This per diem will then be inflated by the estimated inflation rate as calculated under paragraph (B) of this rule and added to the per diem for the franchise permit fee as calculated under rule 5101:3-3-82.1 of the Administrative Code to determine the total other protected cost component of the prospective rate:
- (B) ODJFS shall estimate the rate of inflation for the eighteen-month period using the consumer price index for all urban consumers for nonprescription drugs and medical supplies, as published by the United States bureau of labor statistics. The estimated inflation rate is calculated by taking the index as of the thirty-first day of December in the fiscal year the rate will be paid, divided by the index as of the first day of July in the immediately preceding calendar year. If the estimated inflation rate for the eighteen-month period is different from the actual inflation rate for that period, the difference shall be added to or subtracted from the inflation rate estimated for the following fiscal year.

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5101:3-3-82.1 —Method for establishing reimbursement to intermediate care facilities for the mentally retarded (ICFs-MR) for the franchise permit fee.

(A) For each ICF-MR subject to the franchise fee assessment as specified in ~~rules 5101:3-3-30 to 5101:3-3-30.4 of the Administrative Code~~ sections 5112.30 to 5112.39 of the Revised Code, the Ohio department of job and family services (ODJFS) shall include a franchise permit fee rate add-on in its the prospective per diem rate. The ICF-MR will not receive reimbursement for the franchise permit fee as a rate add-on if there is no assessment. Notwithstanding the methodology of reimbursement for other protected care costs, as set forth under rules 5101:3-3-01, 5101:3-3-82, and 5101:3-3-71 of the Administrative Code, the reimbursement methodology for franchise permit fee is set forth below.

~~(A)(B) A franchise permit fee will be assessed as specified in rule 5101:3-3-30.1 of the Administrative Code.~~ The department of job and family services shall pay a provider for each of the provider's eligible ICFs-MR a per resident per day rate for the franchise permit fee for the ICFs-MR Medicaid residents. The franchise permit fee rate add-on is not subject to the inflation factor that is allowed for costs reported in the other protected care cost center as referenced in rule 5101:3-3-82 of the Administrative Code.

~~(B) For ICFs-MR which are new to the medical assistance program, the per diem rate shall be determined as set forth below.~~

~~(1) A franchise permit fee will be assessed as specified in rule 5101:3-3-30.1 of the Administrative Code. The department of job and family services shall pay a provider for each of the provider's eligible ICFs-MR a per resident per day rate for the franchise permit fee for the ICFs-MR Medicaid residents. The franchise permit fee rate add-on is not subject to the inflation factor that is allowed for costs reported in the other protected care cost center as referenced in rule 5101:3-3-82 of the Administrative Code.~~

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**Method for establishing the indirect care costs component of the prospective rate for intermediate care facilities for the mentally retarded (ICFs-MR).**

(A) The Ohio department of job and family services (ODJFS) shall pay each eligible ICF-MR a per resident per day rate for indirect care costs established prospectively each fiscal year for each facility. The rate for each ICF-MR shall be the sum of the following, but shall not exceed the maximum rate established for the facility's peer group:

(1) The facility's desk-reviewed, actual, allowable, per diem indirect care costs from the calendar year preceding the fiscal year in which the rate will be paid, adjusted for the inflation rate estimated under paragraph (D)(1) of this rule; and

(2) An efficiency incentive of the following amount:

(a) For fiscal years that end in even-numbered calendar years, the following amount:

(i) In the case of an ICF-MR with more than eight beds, seven and one tenth per cent of the maximum rate calculated under paragraph (B) of this rule.

(ii) In the case of an ICF-MR with eight or fewer beds, seven per cent of the maximum rate calculated under paragraph (C) of this rule.

(b) For fiscal years that end in odd-numbered calendar years, the amount calculated for the preceding fiscal year under (A)(2)(a) of this rule.

(B) The maximum rate for indirect care costs of ICFs-MR with more than eight beds shall be determined as follows:

(1) For fiscal years that end in even-numbered calendar years, set the maximum rate of ICFs-MR as follows:

(a) Calculate the per diem indirect care cost under paragraph (A)(1) of this rule for each ICF-MR excluding any ICF-MR that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid; and

(b) Calculate the mean and standard deviation from the per diem indirect care cost established under paragraph (B)(1)(a) of this rule; and

(c) Calculate three standard deviations from the mean established in paragraph (B)(1)(b) of this rule; and

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- (d) Determine each ICF-MR in which the per diem indirect care cost is more than three standard deviations above or below the mean calculated under paragraph (B)(1)(c) of this rule and any ICF-MR that serves residents who have outlier service needs and for which rates have been set pursuant to rule 5101:3-3-17.5 of the Administrative Code; and
- (e) Array the per diem indirect care cost from the calculation under paragraph (B)(1)(a) of this rule excluding the ICFs-MR determined under paragraph (B)(1)(d) of this rule in ascending order for each facility and calculate the per diem indirect care cost which reflects the median medicaid day; and
- (f) Multiply the median as calculated under paragraph (B)(1)(e) of this rule times one hundred twelve and four-tenths per cent to obtain the maximum rate for indirect care costs.
- (2) For fiscal years ending in odd-numbered calendar years, the maximum rate for indirect care costs is the maximum rate for the previous fiscal year as established under paragraph (B)(1)(f) of this rule, adjusted for the inflation rate estimated under paragraph (D)(2) of this rule.
- (3) ODJFS shall not recalculate a maximum rate for indirect care costs set under paragraph (B) of this rule based on additional information that ODJFS receives after the maximum rate is set. ODJFS shall recalculate a maximum rate for indirect care costs only if it made an error in computing the maximum rate based on the information available at the time of the original calculation.
- (C) The maximum rate for indirect care costs of ICFs-MR with eight or fewer beds shall be determined as follows:
- (1) For fiscal years that end in even-numbered calendar years, set the maximum rate of ICFs-MR as follows:
- (a) Calculate the per diem indirect care cost under paragraph (A)(1) of this rule for each ICF-MR excluding any ICF-MR that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid; and
- (b) Calculate the mean and standard deviation from the per diem indirect care cost established under paragraph (C)(1)(a) of this rule; and
- (c) Calculate three standard deviations from the mean established in paragraph (C)(1)(b) of this rule; and
- (d) Determine each ICF-MR in which the per diem indirect care cost is more

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or less than three standard deviations from the mean calculated under paragraph (C)(1)(c) of this rule and any ICF-MR that serves residents who have special care needs pursuant to rule 5101:3-3-17.5 of the Administrative Code; and

(e) Array the per diem indirect care cost from the calculation under paragraph (C)(1)(a) of this rule excluding the ICFs-MR determined under paragraph (C)(1)(d) of this rule in ascending order for each facility and calculate the per diem indirect care cost which reflects the median medicaid day; and

(f) Multiply the median as calculated under paragraph (C)(1)(e) of this rule times one hundred ten and three-tenths per cent to obtain the maximum rate for indirect care costs.

(2) For fiscal years ending in odd-numbered calendar years, the maximum rate for indirect care costs is the maximum rate for the previous fiscal year as established under paragraph (C)(1)(f) of this rule, adjusted for the inflation rate estimated under paragraph (D)(2) of this rule.

(3) ODJFS shall not recalculate a maximum rate for indirect care costs set under paragraph (C) of this rule based on additional information that ODJFS receives after the maximum rate is set. ODJFS shall recalculate a maximum rate for indirect care costs only if it made an error in computing the maximum rate based on the information available at the time of the original calculation.

(D) For purposes of estimating the inflation rates for ICFs-MR under the provisions of this rule, the following applies:

(1) When adjusting rates for inflation under paragraph (A)(1) of this rule, ODJFS shall estimate the rate of inflation for the eighteen-month period beginning on the first day of July of the calendar year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(2) When adjusting rates for inflation under paragraph (B)(2) or (C)(2) of this rule, ODJFS shall estimate the rate of inflation for the twelve-month period beginning on the first day of January of the fiscal year preceding the fiscal year in which the rate will be paid and ending on the thirty-first day of December of the fiscal year in which the rate will be paid, using the consumer price index for all items for all urban consumers for the north central region, published by the United States bureau of labor statistics.

(3) If the inflation rate estimated under paragraph (D)(1) or (D)(2) of this rule is different from the actual inflation rate for the relevant time period, as

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measured using the same index, the difference shall be added to or subtracted from the inflation rate estimated pursuant to this paragraph for the following fiscal year.

(E) For the ICFs-MR excluded under paragraphs (B)(1)(a) and (C)(1)(a) of this rule that participated in the medical assistance program under the same operator for less than twelve months during the calendar year preceding the fiscal year in which the rate will be paid, reimbursement shall be made in accordance with rule 5101:3-3-86 of the Administrative Code.

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5101:3-3-84                    Method for establishing capital reimbursement for intermediate care facilities for the mentally retarded (ICFs-MR).

The Ohio department of job and family services (ODJFS) shall pay each eligible ICF-MR a per resident per day rate for its reasonable capital costs established prospectively each fiscal year for each ICF-MR. Except as otherwise provided under Chapter 5101:3-3 of the Administrative Code, the rate shall be based upon the ICF-MR's capital costs for the calendar year preceding the fiscal year in which the rate will be paid.

(A) The rate for ICFs-MR with more than eight beds shall be the sum of the following:

(1) The allowable per diem cost of ownership is the lesser of the following:

(a) The facility's desk-reviewed, actual, allowable, per diem cost of ownership as set forth under rule 5101:3-3-84.2 of the Administrative Code; or

(b) The maximum ceiling for cost of ownership as set forth under rule 5101:3-3-84.2 of the Administrative Code; and

(2) Any efficiency incentive determined under rule 5101:3-3-84.2 of the Administrative Code; and

(3) The allowable per diem nonextensive renovation costs is the lesser of the following:

(a) The facility's desk-reviewed, actual, allowable, per diem nonextensive renovation as set forth under rule 5101:3-3-84.3 of the Administrative Code; or

(b) The maximum ceiling for nonextensive renovation as set forth under rule 5101:3-3-84.3 of the Administrative Code; and

(4) Any return on net equity as determined under rule 5101:3-3-84.4 of the Administrative Code.

(B) With the exception of the amount determined under paragraph (B)(4) of this rule, the rate for ICFs-MR with eight or fewer beds shall be the sum of the following and shall not exceed the sum of the maximum ceiling as set forth under paragraphs (A)(1)(b) and (A)(3)(b) of this rule.

(1) The allowable per diem cost of ownership is the lesser of the following:

(a) The facility's desk-reviewed, actual, allowable, per diem cost of ownership as set forth under rule 5101:3-3-84.2 of the Administrative Code; or

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- (b) The maximum ceiling for cost of ownership as set forth under rule 5101:3-3-84.2 of the Administrative Code; and
- (2) Any efficiency incentive determined under rule 5101:3-3-84.2 of the Administrative Code; and
- (3) The allowable per diem nonextensive renovation costs is the lesser of the following:
  - (a) The facility's desk-reviewed, actual, allowable, per diem nonextensive renovation as set forth under rule 5101:3-3-84.3 of the Administrative Code; or
  - (b) The maximum ceiling for nonextensive renovation as set forth under rule 5101:3-3-84.3 of the Administrative Code; and
- (4) Any return on net equity as determined under rule 5101:3-3-84.4 of the Administrative Code.

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**Cost of ownership and efficiency incentive for intermediate care facilities for the mentally retarded (ICFs-MR).**

The costs of ownership directly attributable to the purchase, rent, or lease of property and equipment costs from one related party to another through common ownership or control as defined under rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase, rent, or lease of property and equipment costs or the actual costs of the related party.

(A) The desk-reviewed, actual, allowable, per diem cost of ownership is based upon certified beds for property costs and equipment set forth under paragraphs (A)(1) to (A)(3) of this rule for the calendar year preceding the fiscal year in which the rate will be paid, except as otherwise specified under rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code. The desk-reviewed actual, allowable, per diem cost of ownership includes:

(1) The costs of ownership directly related to purchasing or acquiring capital assets include:

(a) Except as otherwise required by rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code, depreciation expense for the cost of building(s) equal to the actual cost depreciated under rule 5101:3-3-84.1 of the Administrative Code. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.

(b) Except as otherwise required by rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code, depreciation expense for major components of property and fixed equipment equal to the actual cost depreciated under rule 5101:3-3-84.1 of the Administrative Code. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.

(c) Except as otherwise required by rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code, depreciation expense for major movable equipment equal to the actual cost depreciated under rule 5101:3-3-84.1 of the Administrative Code. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.

(d) Interest expense incurred on money borrowed for construction or the

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purchase of real property, major components of that property, and equipment.

(e) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period.

(f) Amortization expense of financing costs.

(2) The costs of ownership directly related to renting or leasing capital assets is the desk-reviewed, actual, allowable rent or lease expense of property and equipment.

(3) The costs of ownership directly related to the amortization of leasehold improvements. These costs shall be expensed over the lesser of the remaining life of the lease, but not less than five years, or the useful life of the improvement as specified under rule 5101:3-3-84.1 of the Administrative Code. If the useful life of the improvement is less than five years, it may be amortized over its useful life. Options on leases will not be considered. Effective July 1, 1993, lessees who report leasehold improvements and who leave the program before the minimum amortization period is complete, as set forth under paragraph (A)(3) of this rule, will not receive reimbursement for the balance of unamortized costs.

(B) Cost of ownership payments to ICFs-MR with more than eight beds shall not exceed the following ceilings based upon each facility's own specific date of licensure and cost of construction updated for inflation under paragraph (E) of this rule:

(1) For facilities with dates of licensure prior to January 1, 1958, two dollars and fifty cents per resident day;

(2) For facilities with dates of licensure after December 31, 1957, but prior to January 1, 1968:

(a) Three dollars and fifty cents per resident day if the cost of construction was three thousand five hundred dollars or more per bed;

(b) Two dollars and fifty cents per resident day if the cost of construction was less than three thousand five hundred dollars per bed.

(3) For facilities with dates of licensure after December 31, 1967, but prior to January 1, 1976:

(a) Four dollars and fifty cents per resident day if the cost of construction was five thousand one hundred fifty dollars or more per bed;

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- (b) Three dollars and fifty cents per resident day if the cost of construction was less than five thousand one hundred fifty dollars per bed, but exceeded three thousand five hundred dollars per bed;
  - (c) Two dollars and fifty cents per resident day if the cost of construction was three thousand five hundred dollars or less per bed.
- (4) For facilities with dates of licensure after December 31, 1975, but prior to January 1, 1979:
- (a) Five dollars and fifty cents per resident day if the cost of construction was six thousand eight hundred dollars or more per bed;
  - (b) Four dollars and fifty cents per resident day if the cost of construction was less than six thousand eight hundred dollars per bed but exceeded five thousand one hundred fifty dollars per bed;
  - (c) Three dollars and fifty cents per resident day if the cost of construction was five thousand one hundred fifty dollars or less per bed, but exceeded three thousand five hundred dollars per bed;
  - (d) Two dollars and fifty cents per resident day if the cost of construction was three thousand five hundred dollars or less per bed.
- (5) For facilities with dates of licensure after December 31, 1978, but prior to January 1, 1980:
- (a) Six dollars per resident day if the cost of construction was seven thousand six hundred twenty-five dollars or more per bed;
  - (b) Five dollars and fifty cents per resident day if the cost of construction was less than seven thousand six hundred twenty-five dollars per bed but exceeded six thousand eight hundred dollars per bed;
  - (c) Four dollars and fifty cents per resident day if the cost of construction was six thousand eight hundred dollars or less per bed but exceeded five thousand one hundred fifty dollars per bed;
  - (d) Three dollars and fifty cents per resident day if the cost of construction was five thousand one hundred fifty dollars or less but exceeded three thousand five hundred dollars per bed;
  - (e) Two dollars and fifty cents per resident day if the cost of construction was three thousand five hundred dollars or less per bed.
- (6) For facilities with dates of licensure after December 31, 1979, but prior to

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January 1, 1981, not exceeding:

(a) Twelve dollars per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars per resident day if the beds were originally licensed as nursing home beds by the department of health.

(7) For facilities with dates of licensure after December 31, 1980, but prior to January 1, 1982, not exceeding:

(a) Twelve dollars per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and forty-five cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(8) For facilities with dates of licensure after December 31, 1981, but prior to January 1, 1983, not exceeding:

(a) Twelve dollars per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Six dollars and seventy-nine cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(9) For facilities with dates of licensure after December 31, 1982, but prior to January 1, 1984, not exceeding:

(a) Twelve dollars per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and nine cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(10) For facilities with dates of licensure after December 31, 1983, but prior to January 1, 1985, not exceeding:

(a) Twelve dollars and twenty-four cents per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and twenty-three cents per resident day if the beds were

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originally licensed as nursing home beds by the department of health.

(11) For facilities with dates of licensure after December 31, 1984, but prior to January 1, 1986, not exceeding:

(a) Twelve dollars and fifty-three cents per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and forty cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(12) For facilities with dates of licensure after December 31, 1985, but prior to January 1, 1987, not exceeding:

(a) Twelve dollars and seventy cents per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and fifty cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(13) For facilities with dates of licensure after December 31, 1986, but prior to January 1, 1988, not exceeding:

(a) Twelve dollars and ninety-nine cents per resident day if the beds were originally licensed as residential facility beds by the department of mental retardation and developmental disabilities;

(b) Seven dollars and sixty-seven cents per resident day if the beds were originally licensed as nursing home beds by the department of health.

(14) For facilities with dates of licensure after December 31, 1987, but prior to January 1, 1989, not exceeding thirteen dollars and twenty-six cents per resident day;

(15) For facilities with dates of licensure after December 31, 1988, but prior to January 1, 1990, not exceeding thirteen dollars and forty-six cents per resident day;

(16) For facilities with dates of licensure after December 31, 1989, but prior to January 1, 1991, not exceeding thirteen dollars and sixty cents per resident day;

(17) For facilities with dates of licensure after December 31, 1990, but prior to January 1, 1992, not exceeding thirteen dollars and forty-nine cents per resident day;

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(18) For facilities with dates of licensure after December 31, 1991, but prior to January 1, 1993, not exceeding thirteen dollars and sixty-seven cents per resident day;

(19) For facilities with dates of licensure after December 31, 1992, not exceeding fourteen dollars and twenty-eight cents per resident day.

(C) Cost of ownership payments to ICFs-MR with eight or fewer beds shall not exceed the following ceilings:

(1) For ICFs-MR that have dates of licensure or have been granted project authorization by the department of mental retardation and developmental disabilities before July 1, 1993, and for ICFs-MR of eight or fewer beds that have dates of licensure or have been granted project authorization after that date if the ICF-MR demonstrates that it made substantial commitments of funds before July 1, 1993, cost of ownership payments shall not exceed the following ceilings:

(a) For the fiscal year beginning July 1, 1993, eighteen dollars and forty cents per resident day; and

(b) For the fiscal year beginning July 1, 1994, eighteen dollars and forty cents per resident day, adjusted to reflect the rate of inflation for the twelve-month period beginning July 1, 1992, and ending June 30, 1993, using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics; and

(c) For subsequent fiscal years, the limitation in effect during the previous fiscal year, adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics.

(2) For ICFs-MR that have dates of licensure or that have been granted project authorization by the department of mental retardation and developmental disabilities on or after July 1, 1993, for which substantial commitments of funds were not made before July 1, 1993, cost of ownership payments shall not exceed the applicable amount calculated under paragraph (C)(1) of this rule, if the Ohio department of job and family services (ODJFS) gives prior approval for construction of the facility. If ODJFS does not give prior approval, cost of ownership payments shall not exceed the amount specified in paragraph (B)(6) of this rule as adjusted for inflation under paragraph (E) of this rule. The prior approval process for the purpose of increasing cost of

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ownership payments for new beds or relocated beds is as follows:

(a) Prior to commencement of construction, the provider must submit a request in writing to the ODJFS, bureau of long-term care facilities reimbursement section designee for a higher cost of ownership ceiling prior to initiation of construction of the new facility. This request should include:

(i) The projected completion date for the new ICF-MR facility.

(ii) A copy of the department of mental retardation and developmental disabilities approval.

(iii) A projected budget for the new ICF-MR facility that includes a projected three month cost report that contains all cost centers and inpatient days so that an overall rate can be calculated. For beds relocated from an existing facility, the same information must be received for the existing facility and the facility to which the beds are to be relocated.

(b) ODJFS shall review the proposal and the projected budget, comparing the projected cost per diem to the rate currently associated with the beds for cost neutrality to the Ohio medicaid program. Cost neutrality will be evaluated across beds transferred to the new facility (or facilities) and the beds remaining in the existing facility.

(c) Approval for the increased cost of ownership payments will be granted contingent upon the receipt by ODJFS of the provider's filed actual cost report for the first three months of operation confirming cost neutrality to the Ohio medicaid program. Until a final determination is made by ODJFS with regard to the request for increased cost of ownership payments, the lower cost of ownership ceiling will be effective.

(d) Written approval or denial of the preliminary request will be made by ODJFS within sixty days of the date the initial request was made and the required documentation was received. Written documentation of the final determination will be provided by ODJFS within sixty days from the date the new facility's actual three month cost report is received.

(e) If the project continues to satisfy the cost neutrality standard, the higher cost of ownership ceiling will be implemented retroactively to the first day the new facility's medicaid provider agreement was effective. If the request is denied, the provider will continue to receive the lower cost of ownership ceiling.

(3) Notwithstanding the provisions of rule 5101:3-3-84.3 of the Administrative Code and paragraphs (C)(1) and (C)(2) of this rule, the total payment for cost

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of ownership, cost of ownership efficiency incentive, and capitalized costs of renovations for ICFs-MR with eight or fewer beds shall not exceed the sum of the ceilings as specified under paragraph (B)(6) of this rule as adjusted-for inflation under paragraph (E) of this rule and the provisions of rule 5101:3-3-84.3 of the Administrative Code.

(D) ODJFS shall pay each ICF-MR an efficiency incentive that is equal to fifty per cent of the difference between the following:

(1) The ICF-MR's desk-reviewed, actual, allowable, per diem cost of ownership which includes depreciation for costs that are paid or reimbursed by any government agency;

(2) The applicable efficiency incentive ceiling for each ICF-MR:

(a) For ICFs-MR with more than eight beds, the applicable ceiling as specified under paragraph (B) of this rule based upon each facility's own specific date of licensure and cost of construction updated for inflation under paragraph (E) of this rule; and

(b) For ICFs-MR with eight and fewer beds, the applicable ceiling as specified under paragraph (B) of this rule based upon each facility's own specific date of licensure and cost of construction updated for inflation under paragraph (E) of this rule.

(i) For fiscal year beginning July 1, 1993, the maximum efficiency incentive payment as calculated under paragraph (D) of this rule for ICFs-MR with eight or fewer beds shall not exceed a ceiling of three dollars per resident day; and

(ii) For fiscal year beginning July 1, 1994, and thereafter, the three dollars per resident day is updated for inflation under paragraph (E) of this rule.

(E) For purposes of increasing the ceilings specified under paragraphs (B) and (D)(2) of this rule, the following applies:

(1) For fiscal year that begins July 1, 1993, adjust the ceilings specified under paragraphs (B) and (D)(2) of this rule to reflect the rate of inflation for the twelve month period beginning July 1, 1991 through June 30, 1992 using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics.

(2) For subsequent fiscal years, each of the ceilings, as increased from the prior fiscal year, shall be adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year

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preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics.

(F) ICFs-MR which complete extensive renovations as defined under rule 5101:3-3-01 of the Administrative Code, will receive a per diem for cost of ownership based upon the costs as specified under paragraph (A) of this rule. The per diem for cost of ownership reflects actual expenditures subject to the provisions under rule 5101:3-3-84 of the Administrative Code.

- (1) The date of licensure for an extensively renovated ICF-MR shall be considered to be the date of completion of the extensive renovation.
- (2) The current ceilings as calculated under paragraphs (B), (C), and (D)(2) of this rule shall be assigned to the extensively renovated facility using the date of licensure as determined under paragraphs (B) and (C) of this rule.
- (3) An extensively renovated ICF-MR, which obtains new ceilings as determined under paragraphs (B), (C), and (D)(2) of this rule, shall not be permitted any reimbursement for nonextensive renovations under rule 5101:3-3-84.3 of the Administrative Code made prior to the extensive renovation project which resulted in the new ceilings. Thereafter, the cost and accumulated depreciation of the nonextensive renovation shall be included in cost of ownership.
- (4) An extensively renovated ICF-MR shall not be permitted to receive any reimbursement for nonextensive renovations under rule 5101:3-3-84.3 of the Administrative Code for a period of five years after the completion of the extensive renovations, with the exception of those nonextensive renovations necessary to meet the requirements of federal, state or local statutes, ordinances, rules or policies.

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**Nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR).**

The desk-reviewed actual, allowable, per diem cost for nonextensive renovations established in this rule is subject to the provisions set forth under rule 5101:3-3-84 of the Administrative Code. ICFs-MR which complete renovations as defined under 5101:3-3-01 of the Administrative Code and completed allowable renovations prior to July 1, 1993, will receive the lesser of the ceiling determined under paragraph (G) of this rule or an aggregate per diem based upon the costs as specified in this rule. The cost of nonextensive renovation(s) directly attributable to the purchase of property and equipment costs from one related party to another through common ownership or control as defined under rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase of property and equipment costs or the actual costs of the related party. In order for costs to qualify for cost of nonextensive renovations, the following circumstances must be met.

(A) The desk-reviewed actual, allowable, per diem cost of nonextensive renovation is based upon certified beds for property costs and assets affixed to the building as set forth under paragraphs (A)(1) to (A)(2) of this rule for the calendar year preceding the fiscal year in which the rate will be paid. The desk reviewed actual, allowable, per diem cost of nonextensive renovation includes:

(1) The cost of purchasing or acquiring capital assets that meet the requirements of nonextensive renovation(s) set forth under this rule include:

(a) Except as otherwise required by rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code, depreciation expense for the cost of building(s) equal to the actual cost depreciated under rule 5101:3-3-71.3 of the Administrative Code for nonextensive renovations. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.

(b) Except as otherwise required by rules 5101:3-3-84.5 and 5101:3-3-86 of the Administrative Code, depreciation expense for major components of property and fixed equipment equal to the actual cost depreciated under rule 5101:3-3-71.3 of the Administrative Code for nonextensive renovations. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.

(c) Interest expense incurred on money borrowed for capital assets that qualify for nonextensive renovations.

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(d) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period. These capital asset(s) must qualify for nonextensive renovation.

(e) Amortization expense of financing costs.

(2) The cost of nonextensive renovation(s) directly related to the amortization of leasehold improvements that meet the criteria for nonextensive renovations under this rule. These costs shall be expensed over the lesser of the remaining life of the lease, but not less than five years, or the useful life of the improvement as specified in rule 5101:3-3-71.3 of the Administrative Code. If the useful life of the improvement is less than five years, it may be amortized over its useful life. Options on leases will not be considered. Lessees who report leasehold improvements and who leave the program before the minimum amortization period is complete will not receive reimbursement for the balance of unamortized costs.

(B) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation. For purposes of this rule, "started" means the physical work has begun on the project at the site of the facility. Preliminary work such as planning, agency approval, feasibility surveys, and architectural drawings are not considered "started".

(1) The project results in the betterment, improvement, or restoration of a ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed; and

(2) When applying the five hundred dollars per bed requirement the following apply:

(a) If the project affects only the medicaid certified part of a facility, all medicaid certified beds in the facility will be considered when applying the minimum cost criteria; or

(b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and

(3) The project does not increase the number of licensed beds; and

(4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in paragraph (B) of this rule unless the project meets the definition of extensive renovation as defined under rule 5101:3-3-01 of the Administrative Code; and

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- (5) The ICF-MR has obtained prior approval under paragraph (D) of this rule; and
  - (6) The ICF-MR has satisfied all requirements for notice to the Ohio department of job and family services (ODJFS) upon completion of the project as set forth under paragraph (F)(1) of this rule; and
  - (7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the ICF-MR that is proposed to be renovated.
- (C) To obtain prior approval from ODJFS to report a project as a nonextensive renovation, the following information must be submitted by the ICF-MR prior to beginning construction of the proposed nonextensive renovation.
- (1) A brief description of the project including the need for the project; and
  - (2) An estimate of the cost of the project, a list of work items summarizing the scope of the project, a copy of the estimate from the contractor that will undertake the project, and estimated total annual depreciation and interest expense for the project; and
  - (3) A sketch, diagram, or illustration of the facility prior to the project; and
  - (4) A sketch, diagram, or illustration of the facility showing the layout after completion of the project; and
  - (5) The estimated start and completion date of the project; and
  - (6) If the ICF-MR is requesting an approval of a project under paragraph (B)(7) of this rule, the applicable statute, ordinance, rules or policy must be submitted along with an explanation of how the project addresses the government mandate; and
  - (7) The request must show the number of beds affected by each component of the project in order to determine the minimum cost requirement set forth under paragraph (B)(2) of this rule.
- (D) When reviewing a request for prior approval to report a project as a nonextensive renovation, ODJFS shall:
- (1) Request in writing any additional information needed to review the request for prior approval; and
  - (2) Determine that the project meets the definition of a renovation under rule 5101:3-3-01 of the Administrative Code; and

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- (3) Determine that the project satisfies all the requirements of a nonextensive renovation as set forth under paragraph (B) of this rule; and
- (4) Determine that the estimated costs of the project are allowable under rule 5101:3-3-01 of the Administrative Code; and
- (5) Notify the provider in writing that the request for prior approval to report a project as a nonextensive renovation has been granted or denied. After prior approval is granted, the provider shall comply with the following:
- (a) The nonextensive renovation project must be started within six months after the date ODJFS grants approval; and
- (b) The nonextensive renovation project must be completed within eighteen months after it is started. The total cost of all portions of the nonextensive renovation project completed within eighteen months after it is started must satisfy the cost per bed requirement under paragraph (B)(1) of this rule. Failure to satisfy the conditions under this paragraph shall result in costs of the project being reported as cost of ownership in lieu of nonextensive renovations in accordance with paragraph (F)(3) of this rule.
- (6) Written approval from ODJFS of a project as a nonextensive renovation shall clearly state that the approval of any additional costs as set forth under paragraph (E) of this rule must be approved in writing by ODJFS in order to qualify as nonextensive renovation.
- (E) Additional notice to ODJFS is required during the course of the construction of the approved nonextensive renovation if any of the following circumstances occur:
- (1) The completion of the nonextensive renovation project is delayed or accelerated by more than four months from the estimated date of completion.
- (2) The actual cost of construction exceeds the approved cost by the greater of ten per cent or two thousand dollars.
- (a) Upon receiving notice of the cost increase, ODJFS may approve the additional project costs for inclusion as a nonextensive renovation. In reviewing a project for approval under this paragraph, ODJFS shall apply the criteria specified in paragraph (D) of this rule; or
- (b) If ODJFS does not approve the additional costs, expenses related to all costs in excess of the approved amount will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code; or
- (c) If the provider fails to provide notice to ODJFS of the increased costs,

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expenses related to all costs in excess of the approved amount will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code.

(3) The actual amount financed exceeds the approved amount financed by the greater of ten per cent or two thousand dollars.

(a) Upon receiving notice of the increase in the amount financed, ODJFS may approve the increase in the amount financed for inclusion as a nonextensive renovation. In reviewing a project for approval under paragraph (E)(3)(a) of this rule, ODJFS shall apply the criteria specified in paragraph (D) of this rule; or

(b) If ODJFS does not approve the additional amount financed, interest expense related to all amounts financed in excess of the approved amount will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code; or

(c) If the provider fails to provide notice to ODJFS of the increased amount financed, interest expense related to all amounts financed in excess of the approved amount will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code.

(4) The actual interest rate exceeds the projected interest rate by two percentage points or more.

(a) Upon receiving notice of the increased interest rate, ODJFS may approve the interest expense associated with the increased interest rate for inclusion as nonextensive renovations. In reviewing a project for approval under paragraph (F)(4)(a) of this rule, ODJFS shall apply the criteria specified in paragraph (E) of this rule; or

(b) If ODJFS does not approve the increased interest rate, the interest expense associated with the incremental increase in the approved interest rate will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code; or

(c) If the provider fails to provide notice to ODJFS of the increased interest rate, the interest expense associated with the incremental increase in the approved interest rate will be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code.

(5) Any increase or decrease in the scope of the nonextensive renovation project.

(a) Upon receiving notice of the change in the scope of the nonextensive renovation project, ODJFS may approve the project as revised if the change in scope bears a reasonable relationship to the approved

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nonextensive renovation project; or

(b) If ODJFS does not approve the project as revised, the additional costs associated with the increase in scope shall be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code; or

(c) If the provider fails to provide notice to ODJFS of the change in the scope of the project, the additional costs associated with the increase in scope shall be reported as cost of ownership pursuant to rule 5101:3-3-85 of the Administrative Code.

(6) Any change of cost that causes the project to exceed the threshold for being considered an extensive renovation or to fall below the threshold for being considered a nonextensive renovation.

(F) An approved nonextensive renovation project shall be reported as follows:

(1) Before a nonextensive renovation or portion thereof can be reported on a cost report, notice of completion must be submitted to ODJFS. The notice of completion must include:

(a) The date the project or portion thereof was placed in service; and

(b) Detailed depreciation and amortization schedules and a narrative explanation of any material differences between the expenses stated on the schedules and the estimated costs submitted for the project under paragraph (C)(2) of this rule; and

(c) A detailed reconciliation of actual financing costs to the projected financing cost in the request for approval of a nonextensive renovation.

(2) A nonextensive renovation may be reported on the cost report as each portion of the project is placed into service as long as the anticipated completion of the portions of the project is still within the period set forth under paragraph (E)(5) of this rule and in the aggregate satisfy the five hundred dollar bed requirement under paragraph (B)(1) of this rule.

(3) If the total cost of all the portions of the entire project that have been placed into service within the period set forth under paragraph (D)(5) of this rule do not satisfy the cost per bed requirement under paragraph (B)(1) of this rule, the costs and related expenses for all the portions of the project that have been reported as a nonextensive renovation shall be reported in cost of ownership.

(G) Nonextensive renovation payment shall not exceed the following ceilings:

(1) For the fiscal year beginning July 1, 1994, eight dollars and thirty-six cents per resident day, adjusted to reflect the rate of inflation for the twelve-month

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period beginning July 1, 1992, and ending June 30, 1993, using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics; and

- (2) For subsequent fiscal years, the limitation in effect during the previous fiscal year, adjusted to reflect the rate of inflation for the twelve-month period beginning on the first day of July for the calendar year preceding the calendar year that precedes the fiscal year and ending on the following thirtieth day of June, using the "Consumer Price Index for Shelter Costs for All Urban Consumers for the North Central Region," published by the United States bureau of labor statistics.

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5101:3-3-84.4      **Intermediate care facilities for the mentally retarded (ICFs - MR): return on equity.**

The Ohio department of ~~human services (ODHS)~~ job and family services (ODJFS) shall pay each eligible proprietary ICF-MR a return on the facility's net equity computed from the cost report of the calendar year that precedes the fiscal year in which the rate is paid at the rate of one and one-half times the average interest rate on special issues of public debt obligations issued to the federal hospital insurance trust fund for the cost reporting period. No facility's return on net equity shall exceed one dollar per resident day. When calculating the rate for return on net equity, ~~ODHS~~ ODJFS shall use the greater of the facility's inpatient days during the applicable cost reporting period or the number of inpatient days the facility would have had during that period if its occupancy rate had been ninety-five per cent.

SECTION 309.30.90.

FISCAL YEAR 2012 MEDICAID REIMBURSEMENT  
SYSTEM FOR ICFs-MR

(A) As used in this section:

"Capped per diem rate" means the per diem rate calculated for an ICF-MR under paragraph (D) of this section.

"Change of operator" means an entering operator becoming the operator of an intermediate care facility for the mentally retarded in the place of the exiting operator.

(1) Actions that constitute a change of operator include the following:

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(b) A transfer of all the exiting operator's ownership interest in the operation of the facility to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the facility is also transferred;

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:

(i) The change in composition does not cause the partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

(2) The following, alone, do not constitute a change of operator:

(a) A contract for an entity to manage an intermediate care facility for the mentally retarded as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with an intermediate care facility for the mentally retarded if an entering operator does not become the operator in place of an exiting operator;

(c) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator.

"Entering operator" means the person or government entity that will become the operator of an intermediate care facility for the mentally retarded when a change of operator occurs.

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"Exiting operator" means any of the following:

- (1) An operator that will cease to be the operator of an intermediate care facility for the mentally retarded on the effective date of a change of operator;
- (2) An operator that will cease to be the operator of an intermediate care facility for the mentally retarded on the effective date of a facility closure;
- (3) An operator of an intermediate care facility for the mentally retarded that is undergoing or has undergone a voluntary termination.

"Franchise permit fee" means the fee reimbursed to ICFs-MR under section 5101:3-3-82.1 of Attachment 4.19D of the state plan.

"ICF-MR" means an intermediate care facility for the mentally retarded as defined in section 5101:3-3-01 of Attachment 4.19D of the state plan.

"ICF-MR services" means services covered by the Medicaid program that an ICF-MR provides to a Medicaid recipient eligible for the services.

"Medicaid days" means all days during which a resident who is a Medicaid recipient occupies a bed in an ICF-MR that is included in the ICF-MR's Medicaid-certified capacity. Therapeutic or hospital leave days for which payment is made under section 5101:3-3-16.8 of Attachment 4.19C of the state plan are considered Medicaid days proportionate to the percentage of the ICF-MR's per resident per day rate paid for those days.

"Modified per diem rate" means the per diem rate calculated for an ICF-MR under paragraph (C) of this section.

"Unmodified per diem rate" means the per diem rate calculated for an ICF-MR under Attachment 4.19D of the state plan.

(B) This section applies to each provider of an ICF-MR to which either of the following applies:

- (1) The provider has a valid Medicaid provider agreement for the ICF-MR on June 30, 2011, and a valid Medicaid provider agreement for the ICF-MR during fiscal year 2012.
- (2) The ICF-MR undergoes a change of operator that takes effect during fiscal year 2012, the exiting operator has a valid Medicaid provider agreement for the ICF-MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF-MR during fiscal year 2012.

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(C) An ICF-MR's total modified per diem rate for fiscal year 2012 shall be the ICF-MR's total unmodified per diem rate for that fiscal year with the following modifications:

(1) In place of the inflation adjustment otherwise made under section 5101:3-3-82 of Attachment 4.19D of the state plan, the ICF-MR's desk-reviewed, actual, allowable, per diem other protected costs, excluding the franchise permit fee, from calendar year 2010 shall be multiplied by 1.0123.

(2) In place of the maximum cost per case-mix unit established for the ICF-MR's peer group under section 5101:3-3-79 of Attachment 4.19D of the state plan, the ICF-MR's maximum costs per case-mix unit shall be the following:

(a) In the case of an ICF-MR with more than eight beds, \$108.21;

(b) In the case of an ICF-MR with eight or fewer beds, \$102.21.

(3) In place of the inflation adjustment otherwise calculated under section 5101:3-3-79 of Attachment 4.19D of the state plan, an inflation adjustment of 1.0123 shall be used.

(4) In place of the maximum rate for indirect care costs established for the ICF-MR's peer group under section 5101:3-3-83 of Attachment 4.19D of the state plan, the maximum rate for indirect care costs for the ICF-MR's peer group shall be the following:

(a) In the case of an ICF-MR with more than eight beds, \$68.98;

(b) In the case of an ICF-MR with eight or fewer beds, \$59.60.

(5) In place of the inflation adjustment otherwise calculated under section 5101:3-3-83 of Attachment 4.19D of the state plan, an inflation adjustment of 1.0123 shall be used.

(6) In place of the efficiency incentive otherwise calculated under section 5101:3-3-83 of Attachment 4.19D of the state plan, the ICF-MR's efficiency incentive for indirect care costs shall be the following:

(a) In the case of an ICF-MR with more than eight beds, \$3.69;

(b) In the case of an ICF-MR with eight or fewer beds, \$3.19.

(7) The ICF-MR's efficiency incentive for capital costs, as determined under section 5101:3-3-84.2 of Attachment 4.19D of the state plan, shall be reduced by 50 per cent.

(D) An ICF-MR's total capped per diem rate for fiscal year 2012 shall be the ICF-MR's total unmodified per diem rate for that fiscal year reduced by the percentage by which the mean total unmodified per diem rates for all ICFs-MR in this state for fiscal year 2012, weighted by May 2011 Medicaid days and calculated as of July 1, 2011, exceeds \$282.59.

(E) Except as otherwise provided by this section, the provider of an ICF-MR to which this section applies shall be paid, for ICF-MR services the ICF-MR provides during fiscal year 2012, a total per diem rate determined as follows:

(1) Add the ICF-MR's total modified per diem rate to the ICF-MR's total capped per diem rate;

(2) Divide the amount determined under paragraph (E)(1) of this section by two.

(F) If the mean total per diem rate for all ICFs-MR to which this section applies, weighted by May 2011 Medicaid days and determined under paragraph (E) of this section as of July 1, 2011, is other than \$282.59, the Department of Job and Family Services shall adjust, for fiscal year 2012, the total per diem rate for each ICF-MR to which this section applies by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than \$282.59.

(G) If the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated, the Department of Job and Family Services shall reduce the amount it pays providers of ICF-MR services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.

(H) The Department of Job and Family Services shall follow this section in determining the rate to be paid providers of ICF-MR services subject to this section notwithstanding anything to the contrary in Attachment 4.19D of the state plan.

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**Approval of nonextensive renovations for intermediate care facilities for the mentally retarded (ICFs-MR).**

(A) The following shall apply in order to determine if a project qualifies as a nonextensive renovation for inclusion on the medicaid cost report:

(1) The project results in the betterment, improvement, or restoration of a ICF-MR beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed; and

(2) When applying the five hundred dollars per bed requirement the following apply:

(a) If the project affects only the medicaid certified part of a facility, all medicaid certified beds in the facility will be considered when applying the minimum cost criteria; or

(b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and

(3) The project does not increase the number of licensed beds; and

(4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in paragraph (A) of this rule unless the project meets the definition of extensive renovation; and

(5) The ICF-MR has obtained prior approval under paragraph (C) of this rule; and

(6) The ICF-MR has satisfied all requirements for notice to Ohio department of job and family services (ODJFS) upon completion of the project as set forth under paragraph (E)(1) of this rule; and

(7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the ICF-MR that is proposed to be renovated.

(B) To obtain prior approval from ODJFS to report a project as a nonextensive renovation on the medicaid cost report, the following information must be submitted by the ICF-MR prior to beginning construction of the proposed nonextensive renovation:

(1) A brief description of the project including the need for the project; and

(2) An estimate of the cost of the project, a list of work items summarizing the scope of the project, a copy of the estimate from the contractor that will undertake the project, and estimated total annual depreciation and interest expense for the project; and

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- (3) A sketch, diagram, or illustration of the facility prior to the project; and
  - (4) A sketch, diagram, or illustration of the facility showing the layout after completion of the project; and
  - (5) The estimated start and completion date of the project; and
  - (6) If the ICF-MR is requesting an approval of a project under paragraph (A)(7) of this rule, the applicable statute, ordinance, rules or policy must be submitted along with an explanation of how the project is necessary to meet the requirements of federal, state or local statutes, ordinances, rules or policies; and
  - (7) The request must show the number of beds affected by each component of the project in order to determine the minimum cost requirement set forth under paragraph (A)(2) of this rule.
- (C) When reviewing a request for prior approval to report a project as a nonextensive renovation on the medicaid cost report, ODJFS shall:
- (1) Request in writing any additional information needed to review the request for prior approval; and
  - (2) Determine that the project meets the definition of a renovation; and
  - (3) Determine that the project satisfies all the requirements of a nonextensive renovation as set forth under paragraph (A) of this rule; and
  - (4) Determine that the estimated costs of the project are allowable; and
  - (5) Notify the provider in writing that the request for prior approval to report a project as a nonextensive renovation on the medicaid cost report has been granted or denied. After prior approval is granted, the provider shall comply with the following:
    - (a) The nonextensive renovation project must be started within six months after the date ODJFS grants approval; and
    - (b) The nonextensive renovation project must be completed within eighteen months after it is started. The total cost of all portions of the nonextensive renovation project completed within eighteen months after it is started must satisfy the cost per bed requirement under paragraph (A)(1) of this rule.

For purposes of paragraph (C) of this rule, "started" means the physical work has begun on the project at the site of the facility. Preliminary

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work such as planning, agency approval, feasibility surveys, and architectural drawings are not considered "started". Failure to satisfy the conditions under this paragraph shall result in costs of the project being reported as cost of ownership in lieu of nonextensive renovations in accordance with paragraph (E)(3) of this rule.

(6) Written approval from ODJFS of a project as a nonextensive renovation for inclusion on the medicaid cost report shall clearly state that the approval of any additional costs as set forth under paragraph (D) of this rule must be approved in writing by ODJFS in order to qualify as nonextensive renovation costs.

(D) Additional notice to ODJFS is required during the course of the construction of the approved nonextensive renovation if any of the following circumstances occur:

(1) The completion of the nonextensive renovation project is delayed or accelerated by more than four months from the estimated date of completion.

(2) The actual cost of construction exceeds the approved cost by the greater of ten per cent or two thousand dollars.

(a) Upon receiving notice of the cost increase, ODJFS may approve the additional costs for inclusion as nonextensive renovation costs on the medicaid cost report. In reviewing a project for approval under paragraph (D)(2)(a) of this rule, ODJFS shall apply the criteria specified in paragraph (C) of this rule; or

(b) If ODJFS does not approve the additional costs for inclusion as nonextensive renovation costs on the medicaid cost report, expenses related to all costs in excess of the approved amount will be reported as cost of ownership; or

(c) If the provider fails to provide notice to ODJFS of the increased costs, expenses related to all costs in excess of the approved amount will be reported as cost of ownership.

(3) The actual amount financed exceeds the approved amount financed by the greater of ten per cent or two thousand dollars.

(a) Upon receiving notice of the increase in the amount financed, ODJFS may approve the increase in the amount financed for inclusion as nonextensive renovation costs on the medicaid cost report. In reviewing a project for approval under paragraph (D)(3)(a) of this rule, ODJFS shall apply the criteria specified in paragraph (C) of this rule; or

(b) If ODJFS does not approve the additional amount financed, interest

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expense related to all amounts financed in excess of the approved amount will be reported as cost of ownership; or

(c) If the provider fails to provide notice to ODJFS of the increased amount financed, interest expense related to all amounts financed in excess of the approved amount will be reported as cost of ownership.

(4) The actual interest rate exceeds the projected interest rate by two percentage points or more.

(a) Upon receiving notice of the increased interest rate, ODJFS may approve the interest expense associated with the increased interest rate for inclusion as nonextensive renovation costs on the medicaid cost report. In reviewing a project for approval under paragraph (D)(4)(a) of this rule, ODJFS shall apply the criteria specified in paragraph (C) of this rule; or

(b) If ODJFS does not approve the increased interest rate, the interest expense associated with the incremental increase in the approved interest rate will be reported as cost of ownership; or

(c) If the provider fails to provide notice to ODJFS of the increased interest rate, the interest expense associated with the incremental increase in the approved interest rate will be reported as cost of ownership.

(5) Any increase or decrease in the scope of the nonextensive renovation project.

(a) Upon receiving notice of the change in the scope of the nonextensive renovation project, ODJFS may approve the project as revised if the change in scope bears a reasonable relationship to the approved nonextensive renovation project; or

(b) If ODJFS does not approve the project as revised, the additional costs associated with the increase in scope shall be reported as cost of ownership; or

(c) If the provider fails to provide notice to ODJFS of the change in the scope of the project, the additional costs associated with the increase in scope shall be reported as cost of ownership.

(6) Any change of cost that causes the project to exceed the threshold for being considered an extensive renovation or to fall below the threshold for being considered a nonextensive renovation.

(E) An approved nonextensive renovation project shall be reported as follows:

(1) Before a nonextensive renovation or portion thereof can be reported on a cost

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report, notice of completion must be submitted to ODJFS. The notice of completion must include:

- (a) The date the project or portion thereof was placed in service; and
  - (b) Detailed depreciation and amortization schedules and a narrative explanation of any material differences between the expenses stated on the schedules and the estimated costs submitted for the project under paragraph (B)(2) of this rule; and
  - (c) A detailed reconciliation of actual financing costs to the projected financing cost in the request for approval of a nonextensive renovation.
- (2) A nonextensive renovation may be reported on the cost report as each portion of the project is placed into service as long as the anticipated completion of the portions of the project is still within the period set forth under paragraph (C)(5) of this rule and in the aggregate satisfy the five hundred dollar bed requirement under paragraph (A)(1) of this rule.
- (3) If the total cost of all the portions of the entire project that have been placed into service within the period set forth under paragraph (C)(5) of this rule do not satisfy the cost per bed requirement under paragraph (A)(1) of this rule, the costs and related expenses for all the portions of the project that have been reported as a nonextensive renovation shall be reported in cost of ownership.

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**Exception review process for intermediate care facilities for the mentally retarded.**

(A) ~~Definitions: The terms used in this rule have the same meaning as in rule 5101:3-3-77 of the Administrative Code, or are defined below:~~

(1) "Exception review" is a review conducted at selected intermediate care facilities for the mentally retarded (ICFs-MR) by appropriate health professionals employed by the Ohio department of job and family services (ODJFS), for purposes of identifying any patterns or trends related to the JFS 02221 "Ohio Individual Assessment Form Answer Sheet"(rev. 6/03) submitted in accordance with rule 5101:3-3-75 of the Administrative Code, which result in inaccurate case mix scores being used to calculate the direct care rate.

~~(2) "Effective date of the rate" is the first day of the payment quarter.~~

~~(3)~~(2) "Exception review tolerance level" is the level of variance between the facility and ODJFS in the individual assessment form (IAF) assessment item responses affecting the resident assessment classification of a facility's residents. Two kinds of tolerance levels have been established for exception reviews: initial sample, and expanded review.

(a) "Initial sample tolerance level" is the percentage of unverifiable records found in the initial sample of resident records during the first phase of an exception review, below which no further review will be pursued. The exception review tolerance level for the initial sample of reviewed records from the most recent reporting quarter shall be fifteen per cent of the entire sample as set forth in appendix A of this rule.

(b) "Expanded review tolerance level" is an acceptable level of variance in the calculation of the quarterly facility average case mix score of the ICF-MR. The variance is calculated as a percentage difference between the score based on exception review findings compared to the score based on the submitted assessment records from the facility for that quarter.

(i) For an exception review of the most recent reporting quarter conducted before the effective date of the rate, the exception review tolerance level is a two per cent difference between the quarterly facility average case mix score based on exception review findings and the quarterly facility average case mix score from the facility's submitted IAF records.

(ii) For an exception review of a given reporting quarter conducted after

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the effective date of the rate, the exception review tolerance level is a three per cent difference between the quarterly facility average case mix score based on exception review findings and the quarterly facility average case mix score from the facility's submitted IAF records.

(4)(3) "Verified IAF record" is ~~an~~ JFS 02221, "~~Ohio Individual Assessment Form Answer Sheet,~~" completed by the ICF-MR based on facility-supplied IAF assessment data, submitted to ODJFS for a resident for a specific reporting quarter which, upon examination by ODJFS, has been determined to accurately represent the aspects of the resident's condition, during the specified assessment timeframe, that affect the correct assignment of that record into the resident assessment classification system (RACS) case mix payment system. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents. An "unverified IAF record" is one which, upon examination, has been determined to not accurately represent the resident's condition, and therefore results in the residents inaccurate assignment into the RACS system.

(B) All exception reviews will comply with the applicable rules prescribed pursuant to Titles XVIII (01/02/01 <http://law2.house.gov/>) and XIX (01/02/01 <http://law2.house.gov/>) of the Social Security Act.

(C) Selection: During the selection process, ODJFS may contact the facility for clarification of information. The facility may be able to satisfactorily resolve the department's concerns at this point and avert an on-site review. ICFs-MR may be selected for an exception review by ODJFS based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health that the facility has been issued a deficiency in the condition of participation: active treatment services, as defined by 42 CFR section 483.440 (~~10-1-02~~ 10-1-04 edition <http://www.access.gpo.gov/nara/cfr/index.html>~~http://www.gpoaccess.gov/cfr/index.html~~).

(2) A risk analysis profile of ICFs-MR with a sudden or drastic change in the frequency distribution of their residents in the RACS classes; or ICFs-MR for which other data indicate that the assessment information submitted by the facility may not result in accurate classification of the facility's residents in the RACS system.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessment submission deadlines, error

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rates, and incorrect assessment dates.

(D) Exception reviews shall be conducted at the facility by qualified mental retardation professionals, registered nurses and other licensed or certified health professionals under contract with or employed by ODJFS. When a team of ODJFS reviewers conducts an on-site exception review, the team shall be led by a qualified mental retardation professional. Persons conducting exception reviews on behalf of ODJFS shall meet the following conditions:

(1) During the period of their professional employment with ODJFS, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of an ICF-MR which they review in Ohio.

(2) Reviewers shall not review any facility that has been a client of the reviewer.

(3) Reviewers shall not review any facility that has been an employer of the reviewer.

(4) Employment of a member of a health professional's family by an ICF-MR that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of an ICF-MR.

(E) Prior notice: ODJFS shall notify the facility by telephone and by facsimile at least two working days prior to the review. At the time of notification, ODJFS shall discuss the findings that led the department to decide to conduct an exception review.

(F) Scheduling/rescheduling: Exception reviews of the most recent reporting quarter may be scheduled for any working day of the processing quarter, including the time between that reporting period end date and the filing date. ODJFS shall notify the ICF-MR prior to the previously scheduled time if reviewers are unable to visit the ICF-MR at the arranged time. At the discretion of ODJFS, the review team may reschedule the review if appropriate key personnel of the facility would be unavailable on the originally scheduled date of on-site review. ~~Exception reviews shall not be conducted by ODJFS on dates when inspections of care, as set forth in rule 5101:3-3-15.4 of the Administrative Code, are conducted.~~

(G) Facilities selected for exception reviews must provide ODJFS reviewers with reasonable access to residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments. Facilities must

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also provide ODJFS with sufficient information to be able to contact the resident's attending or consulting physicians, other professionals from all disciplines who have observed, evaluated or treated the resident, such as contracted therapists, and the resident's family/significant others. These sources of information may help to validate information provided on the resident assessment instrument and submitted to ODJFS.

- (H) An exception review shall initially be conducted of a preselected random, targeted, or combination sample of completed resident assessment instruments from the most recent reporting quarter. The initial sample size shall be greater than or equal to the minimum sample size presented in appendix A of this rule.
- (I) Results from review of the initial sample shall be used to decide if further action by ODJFS is warranted. If the initial sample is to be expanded for further review, ODJFS reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. At the time of the conference, facilities shall be afforded an opportunity to present additional information or items which depict the needs of individuals for whom the provider contests the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(3)(a) of this rule, ODJFS:
  - (1) Shall first expand the sample size for the same reporting quarter and continue the review process; and
  - (2) May subsequently expand the exception review process to review IAF assessments submitted for no more than two quarters previous to the most recent reporting quarter.
- (J) At the conclusion of the on-site portion of the exception review process, ODJFS reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify RACS classification for reviewed records. At the time of the exit conference, facilities shall be afforded an opportunity to present additional information or items which depict the needs of individuals for whom the provider contests the sample findings.
- (K) All exception reviews shall include a written summary of findings. ODJFS shall send a copy of the written summary of findings to the ICFs-MR.
- (L) All exception review reports shall be retained by ODJFS for at least six years from the date the exception review report is final.

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(M) If the expanded review tolerance level is exceeded, ODJFS shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly facility average case mix scores and annual facility average case mix scores and ~~adjust the facility's direct care component of the rate accordingly.~~ Calculations or recalculations shall apply only to records actually reviewed by ODJFS; and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODJFS shall recalculate a quarterly facility average case mix score by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

~~(N) ODJFS shall use the quarterly and annual facility average case mix scores based on exception review findings which exceed the exception review tolerance level to calculate or recalculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters. However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average case mix score or a facility cost per case mix unit made in accordance with rule 5101:3-3-77 of the Administrative Code as a result of the facility's failure to submit or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly facility average case mix score or cost per case mix unit than the one to be assigned.~~

~~(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding payment quarter, and the review results in findings that exceed the tolerance level, ODJFS shall use the recalculated quarterly facility average case mix scores to calculate the facility's rate for direct care costs for that payment quarter. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility's submission of assessment information.~~

~~(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding payment quarter, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODJFS shall increase the direct care rate prospectively for the remainder of the payment quarter, beginning one month after the first day of the month after the exception review is completed.~~

~~(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding payment quarter, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODJFS shall reduce the direct care rate and apply it to the periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule 5101:3-3-22~~

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of the Administrative Code.

~~(N)~~(N) Except for additional information submitted to ODJFS as part of the processes set forth in paragraphs (P) and (Q) of this rule, ~~the~~The ODJFS exception review determination for any resident case mix score shall be considered final and the ICF-MR may not correct or amend the IAF data or submit any additional information for that individual record after exception reviewers have concluded the on-site review. An ICF-MR may, however, continue to submit current changes using the IAF correction document in accordance with rule 5101:3-3-77 of the Administrative Code for individual records that were not subject to an exception review finding.

~~(P)~~ The ICFs MR may seek reconsideration in accordance with paragraph (B) of rule 5101:3-3-24 of the Administrative Code for direct care rates recalculated as a result of an exception review conducted before the effective date of the rate.

~~(O)~~(O) The findings of an exception review conducted after the effective date of the rate may be appealed under provisions of the Administrative Procedure Act, Chapter 119, of the Revised Code. ODJFS shall not withhold from the facility's current payments any amounts ODJFS claims to be due from the facility as a result of the exception review findings while the ICF-MR is pursuing administrative remedies in good faith.

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APPENDIX A

EXCEPTION REVIEW RESIDENT INITIAL SAMPLE SELECTION

RESIDENT CENSUS ON REPORTING PERIOD END DATE (REFERENCE <u>JFS 02222</u> )	MINIMUM INITIAL SAMPLE SIZE REQUIRED
1-4	ALL
5-10	5
11-20	8
21-40	10
41-44	11
45-48	12
49-52	13
53-56	14
57-75	15
76-80	16
81-85	17
86-90	18
91-95	19
96-100	20
101-105	21
106-110	22
111-115	23
116-160	24
161-166	25
167-173	26
174-180	27
181-186	28
187-193	29
194-300	30

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**Intermediate Care Facilities for the Mentally Retarded (ICFs-MR): Rates for Providers New to the Medicaid Program.**

(A) The Ohio department of job and family services (ODJFS) shall determine the initial rate for the fiscal year in which the ICF-MR begins participation in the medicaid program for an ICF-MR with a first date of licensure and subsequent certification on or after July 1, 2007, including an ICF-MR that replaces one or more existing facilities, or an ICF-MR with a first date of licensure before that date that was certified for the medicaid program on or after that date under section 5111.255 of the Revised Code as follows:

(1) For the fiscal year in which the ICF-MR begins participation in the medicaid program, the initial rate shall be set as follows:

(a) The rate for direct care costs shall be determined as follows:

(i) The initial rate shall be the cost per case-mix unit (CPCMU) which reflects the median medicaid day of the ICF-MR bed-size group multiplied by the median annual average case-mix score of the ICF-MR bed-size group multiplied by the eighteen-month inflation rate determined for the fiscal year under rule 5101:3-3-79 of the Administrative Code. Both the CPCMU which reflects the median medicaid day of the ICF-MR bed-size group and the median annual average case-mix score of the ICF-MR bed-size group are determined from the calendar year preceding the fiscal year in which the rate will be paid. ODJFS shall assign the ICF-MR to the applicable bed-size group based upon the number of medicaid certified beds of the ICF-MR as determined under rule 5101:3-3-79 of the Administrative Code.

~~(ii) After the ICF-MR submits quarterly assessment information for its first reporting quarter under rule 5101:3-3-73.1 of the Administrative Code, its rate for the following payment quarter shall be calculated using its actual case mix score from the reporting quarter as determined under rule 5101:3-3-73.3 of the Administrative Code instead of the median case mix score prescribed by paragraph (A)(1)(a)(i) of this rule. If either of the ICF-MR's first two quarterly submissions do not contain assessment information that qualifies for use in calculating a case mix score under rule 5101:3-3-73.3 of the Administrative Code, ODJFS shall continue to calculate the rate using the median annual case mix score for the ICF-MR bed-size group and shall not assign a quarterly case mix score as provided in that rule.~~

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(iii)(ii) If the ICF-MR is a replacement facility and the facility or facilities that are being replaced are in operation immediately before the replacement ICF-MR opens, the direct care rate shall be the same as the direct care rate for the replaced facility or facilities, weighted by the number of beds from each replaced facility. If one or more of the replaced facilities is not in operation immediately before the replacement ICF-MR opens, its proportion of the direct care rate shall be determined under paragraph (A)(1)(a)(i) of this rule.

(b) The rate for other protected costs shall be determined as follows:

(i) The initial rate shall be one hundred fifteen percent of the median rate for all ICFs-MR as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-82 of the Administrative Code. The median rate will not include the franchise permit fee. Facilities billed this fee in their initial rate year, will be assigned an amount as provided in paragraph (A) of rule 5101:3-3-82.1 of the Administrative Code.

(c) The rate for indirect care costs shall be determined as follows:

(i) The initial rate shall be the applicable maximum rate for the ICF-MR bed-size group as calculated for the fiscal year in which the rate will be paid under rule 5101:3-3-83 of the Administrative Code. ODJFS shall assign the ICF-MR to the applicable bed-size group based upon the number of medicaid certified beds of the ICF-MR as determined under rule 5101:3-3-83 of the Administrative Code.

(d) The rate for capital costs shall be determined as follows:

(i) The ICF-MR shall be assigned the median capital rate of all ICFs-MR as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-84 of the Administrative Code.

(B) For the following fiscal year the new provider's rate shall be calculated as follows:

(1) For a new ICF-MR provider beginning July first through October first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the year end cost report filed under rule 5101:3-3-20 of the Administrative Code.

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- (2) For a new ICF-MR provider beginning October second through December thirty-first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the three month cost report filed under rule 5101:3-3-20 of the Administrative Code.
  
- (3) For a new ICF-MR provider beginning January first through June thirtieth, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year in accordance with paragraph (A)(1) of this rule.

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5101:3-3-86.1      **Intermediate Care Facilities for the Mentally Retarded (ICFs-MR): Rates for Providers that Change Provider Agreements.**

- (A) For an entering ICF-MR operator, as defined under section 5111.65 of the Revised Code, that begins participation in the medicaid program, the Ohio department of job and family services (ODJFS) shall determine the initial rate as the rate the exiting operator would have received on the date the entering operator begins participation in the medicaid program.
- (B) For the following fiscal year, the entering operator's rate shall be calculated as follows:
- (1) For an entering ICF-MR operator that has a change of provider agreement beginning July first through October first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the year end cost report filed under rule 5101:3-3-20 of the Administrative Code.
  - (2) For an entering ICF-MR operator that has a change of provider agreement beginning October second through December thirty-first, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code for the following fiscal year using the three month cost report filed under rule 5101:3-3-20 of the Administrative Code.
  - (3) For an entering ICF-MR operator that has a change of provider agreement beginning January first through June thirtieth, ODJFS shall set the rate pursuant to sections 5111.20 to 5111.33 of the Ohio Revised Code of the entering operator for the following fiscal year using the exiting operator's cost report from the calendar year preceding the fiscal year.

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SECTION 309.33.10

FISCAL YEAR 2013 MEDICAID REIMBURSEMENT  
SYSTEM FOR ICFs-MR

(A) As used in this section:

"Capped per diem rate" means the per diem rate calculated for an ICF-MR under division (D) of this section.

"Change of operator" means an entering operator becoming the operator of an intermediate care facility for the mentally retarded in the place of the exiting operator.

(1) Actions that constitute a change of operator include the following:

(a) A change in an exiting operator's form of legal organization, including the formation of a partnership or corporation from a sole proprietorship;

(b) A transfer of all the exiting operator's ownership interest in the operation of the facility to the entering operator, regardless of whether ownership of any or all of the real property or personal property associated with the facility is also transferred;

(c) A lease of the facility to the entering operator or the exiting operator's termination of the exiting operator's lease;

(d) If the exiting operator is a partnership, dissolution of the partnership;

(e) If the exiting operator is a partnership, a change in composition of the partnership unless both of the following apply:

(i) The change in composition does not cause the partnership's dissolution under state law.

(ii) The partners agree that the change in composition does not constitute a change in operator.

(f) If the operator is a corporation, dissolution of the corporation, a merger of the corporation into another corporation that is the survivor of the merger, or a consolidation of one or more other corporations to form a new corporation.

(2) The following, alone, do not constitute a change of operator:

(a) A contract for an entity to manage an intermediate care facility for the mentally retarded as the operator's agent, subject to the operator's approval of daily operating and management decisions;

(b) A change of ownership, lease, or termination of a lease of real property or personal property associated with an intermediate care facility for the mentally retarded if an entering operator does not become the operator in place of an exiting operator;

(c) If the operator is a corporation, a change of one or more members of the corporation's governing body or transfer of ownership of one or more shares of the corporation's stock, if the same corporation continues to be the operator.

"Entering operator" means the person or government entity that will become the operator of an intermediate care facility for the mentally retarded when a change of operator occurs.

"Exiting operator" means any of the following:

- (1) An operator that will cease to be the operator of an intermediate care facility for the mentally retarded on the effective date of a change of operator;
- (2) An operator that will cease to be the operator of an intermediate care facility for the mentally retarded on the effective date of a facility closure;
- (3) An operator of an intermediate care facility for the mentally retarded that is undergoing or has undergone a voluntary termination.

"Franchise permit fee" means the fee reimbursed to ICFs-MR under section 5101:3-3-82.1 of Attachment 4.19D of the state plan.

"ICF-MR" means an intermediate care facility for the mentally retarded as defined in section 5101:3-3-01 of Attachment 4.19D of the state plan.

"ICF-MR services" means services covered by the Medicaid program that an ICF-MR provides to a Medicaid recipient eligible for the services.

"Medicaid days" means all days during which a resident who is a Medicaid recipient occupies a bed in an ICF-MR that is included in the ICF-MR's Medicaid-certified capacity. Therapeutic or hospital leave days for which payment is made under section 5101:3-3-16.8 of Attachment 4.19C of the state plan are considered Medicaid days proportionate to the percentage of the ICF-MR's per resident per day rate paid for those days.

"Modified per diem rate" means the per diem rate calculated for an ICF-MR under paragraph (C) of this section.

"Unmodified per diem rate" means the per diem rate calculated for an ICF-MR under Attachment 4.19D of the state plan.

(B) This section applies to each provider of an ICF-MR to which either of the following applies:

- (1) The provider has a valid Medicaid provider agreement for the ICF-MR on June 30, 2012, and a valid Medicaid provider agreement for the ICF-MR during fiscal year 2013.
- (2) The ICF-MR undergoes a change of operator that takes effect during fiscal year 2013, the exiting operator has a valid Medicaid provider agreement for the ICF-MR on the day immediately preceding the effective date of the change of operator, and the entering operator has a valid Medicaid provider agreement for the ICF-MR during fiscal year 2013.

(C) An ICF-MR's total modified per diem rate for fiscal year 2013 shall be the ICF-MR's total unmodified per diem rate for that fiscal year with the following modifications:

- (1) In place of the inflation adjustment otherwise made under section 5101:3-3-82 of Attachment 4.19D of the state plan, the ICF-MR's desk-reviewed, actual, allowable, per

- diem other protected costs, excluding the franchise permit fee, from calendar year 2011 shall be multiplied by 1.0123.
- (2) In place of the maximum cost per case-mix unit established for the ICF-MR's peer group under section 5101:3-3-79 of Attachment 4.19D of the state plan, the ICF-MR's maximum costs per case-mix unit shall be the following:
- (a) In the case of an ICF-MR with more than eight beds, \$108.21;
  - (b) In the case of an ICF-MR with eight or fewer beds, \$102.21.
- (3) In place of the inflation adjustment otherwise calculated under section 5101:3-3-79 of Attachment 4.19D of the state plan, an inflation adjustment of 1.0123 shall be used.
- (4) In place of the maximum rate for indirect care costs established for the ICF-MR's peer group under section 5101:3-3-83 of Attachment 4.19D of the state plan, the maximum rate for indirect care costs for the ICF-MR's peer group shall be the following:
- (a) In the case of an ICF-MR with more than eight beds, \$68.98;
  - (b) In the case of an ICF-MR with eight or fewer beds, \$59.60.
- (5) In place of the inflation adjustment otherwise calculated under section 5101:3-3-83 of Attachment 4.19D of the state plan, an inflation adjustment of 1.0123 shall be used.
- (6) In place of the efficiency incentive otherwise calculated under section 5101:3-3-83 of Attachment 4.19D of the state plan, the ICF-MR's efficiency incentive for indirect care costs shall be the following:
- (a) In the case of an ICF-MR with more than eight beds, \$3.69;
  - (b) In the case of an ICF-MR with eight or fewer beds, \$3.19.
- (7) The ICF-MR's efficiency incentive for capital costs, as determined under section 5101:3-3-84.2 of Attachment 4.19D of the state plan, shall be reduced by 50 per cent.
- (D) An ICF-MR's total capped per diem rate for fiscal year 2013 shall be the ICF-MR's total unmodified per diem rate for that fiscal year reduced by the percentage by which the mean total unmodified per diem rates for all ICFs-MR in this state for fiscal year 2013, weighted by May 2012 Medicaid days and calculated as of July 1, 2012, exceeds \$282.92.
- (E) Except as otherwise provided by this section, the provider of an ICF-MR to which this section applies shall be paid, for ICF-MR services the ICF-MR provides during fiscal year 2013, a total per diem rate determined as follows:
- (1) Add the ICF-MR's total modified per diem rate to the ICF-MR's total capped per diem rate;
  - (2) Divide the amount determined under paragraph (E)(1) of this section by two.

- (F) If the mean total per diem rate for all ICFs-MR to which this section applies, weighted by May 2012 Medicaid days and determined under paragraph (E) of this section as of July 1, 2012, is other than \$282.92, the Department of Job and Family Services shall adjust, for fiscal year 2013, the total per diem rate for each ICF-MR to which this section applies by a percentage that is equal to the percentage by which the mean total per diem rate is greater or less than \$282.92.
- (G) If the United States Centers for Medicare and Medicaid Services requires that the franchise permit fee be reduced or eliminated, the Department of Job and Family Services shall reduce the amount it pays providers of ICF-MR services under this section as necessary to reflect the loss to the state of the revenue and federal financial participation generated from the franchise permit fee.
- (H) The Department of Job and Family Services shall follow this section in determining the rate to be paid providers of ICF-MR services subject to this section notwithstanding anything to the contrary in Attachment 4.19D of the state plan.

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**Prospective rate reconsideration for intermediate care facilities for the mentally retarded (ICFs-MR) for possible calculation errors.**

(A) A facility, group, or association may request a reconsideration of a prospective intermediate care facility for the mentally retarded (ICF-MR) rate on the basis of a possible error in the calculation of the rate as follows:

(1) A request for reconsideration of a prospective rate on the basis of a possible error in the calculation of the rate shall be filed with the Ohio department of job and family services (ODJFS) no more than thirty days after the later of the initial payment of the rate or the receipt of the rate setting calculation.

(2) The request for a reconsideration of a prospective rate on the basis of a possible error in the calculation of the rate shall be filed in accordance with the following procedures:

(a) The request for rate reconsideration shall be in writing; and

(b) The request shall be addressed to "Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section," and

(c) The request shall indicate that it is a request for rate reconsideration due to a possible error in the calculation of the rate; and

(d) The request shall include a detailed explanation of the possible error and the proposed corrected calculation; and

(e) The request shall include references to the relevant sections of the Revised Code and/or paragraphs of the Administrative Code as appropriate.

(3) ODJFS shall respond in writing within sixty days of receiving each written request for reconsideration of a prospective rate due to a possible error in the calculation of the rate. If ODJFS requests additional information to determine whether a rate adjustment is warranted, the ICF-MR shall respond in writing and shall provide additional supporting documentation no more than thirty days after the receipt of the request for additional information. ODJFS shall respond in writing within sixty days of receiving the additional information to the request for reconsideration of a prospective rate due to a possible error in the calculation of the rate.

(4) If a rate adjustment is warranted as the result of a reconsideration of a prospective rate due to a possible error in calculation, the adjustment shall be implemented retroactively to the initial service date for which the rate is effective.

(B) ODJFS's decision at the conclusion of the rate reconsideration process shall not be

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subject to any administrative proceedings under Chapter 119, or any other provision of the Revised Code.

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Date

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