Ohio Department of Job and Family Services

HOSPITAL COST REPORT (JFS 02930)

INSTRUCTIONS

For State Fiscal Year 2011

For Hospitals Using The CMS 2552-96

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GENERAL INSTRUCTIONS

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

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

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

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

FILING DEADLINE

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

The completed cost report MUST BE POSTMARKED on or before June 30, 2011* for those hospitals filing with a cost reporting period ending between July 1, 2010 and December 31, 2010. For those hospitals filing with a cost report period ending between January 1, 2011 and June 30, 2011, the report is to be postmarked no later than December 31, 2011.

*** Due to a delay in the release of the cost report software, hospitals whose cost report would be due on June 30, 2011 have been granted an automatic extension to July 30, 2011.**

SPECIAL FILING DEADLINE FOR SCHEDULES F1, F2 & F3 (F-Series) – Completion of these schedules for the SFY 2011 report period is required for all hospitals operating within Ohio. Hospitals may elect to delay the filing of the completed of F-Series Schedules until the filing of their SFY 2012 Cost Report.

- The total charges reported for each uncompensated care category must match the charges reported on Schedule F of your SFY 2011 interim-settled cost report. Schedules with non-matching charges will be returned to the hospital.
- A hospital may file the completed SFY 2011 F-series schedules at any time prior to the SFY 2012 filing.
- The filing of the SFY 2011 F-series schedules is tied to the filing of the SFY 2012 Hospital Cost Report. If the SFY 2011 F-series schedules are not filed with or before the SFY 2012 Hospital Cost Report, the SFY 2012 report will be considered late and the appropriate penalty will be assessed. The penalty for late or incomplete cost reports is $1,000.00 per day.

REQUIRED FILINGS

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

Filing Due on or before June 30, 2011* (see asterisk previous page)

- the completed CMS-2552-96 electronic cost report (EC) and print image (PI) files
- all completed applicable JFS 02930 schedules

- **Email** the CMS-2552-96 (EC & PI files) and JFS 02930.xls to:

hospital_cost_reports@jfs.ohio.gov

If unable to email, please contact ODJFS.

- **Mail the following cost report information to:**

Via Regular Mail (preferred)	Via Parcel Carriers (not required)
Ohio Health Plans	**Ohio Health Plans**
Rate Setting & Cost Settling Unit	**Rate Setting & Cost Settling Unit**
P.O. Box 182709	**50 W. Town Street, Ste 400, 4th Floor**
Columbus, OH 43218-2709	**Columbus, OH 43215-4142**

An original SIGNED JFS 02930 Certification Page
A hard copy of the JFS 02930 schedules and OBRA Survey
A copy of the SIGNED CMS-2552-96 Certification Page

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

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

FILING EXTENSIONS

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

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

AMENDED FILINGS

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

IMPORTANT REMINDERS

The Upper Limit Payments (UPL) payments reported on Schedule H, col. 1, lines 5 and 14 should be recorded gross, not net.

The OBRA Survey must be completed in its entirety.

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

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

CHANGES

- **The cost report instructions and forms have been updated to reflect dates and filing deadlines relevant to the SFY 2011 Reporting Periods.**
- **Three new schedules (F1, F2, & F3) have been added to facilitate the reporting of Uncompensated Care Data, detailed by cost center. This is necessary in order to fully comply with the Federally mandated DSH Audit requirements (Federal Register Dec. 19, 2008). These schedules align with the already existing Uncompensated Care categories.**
- **The cost report schedules have been expanded to more closely match the CMS 2552-10. Instructions have been prepared to guide hospitals in the completion of the cost report regardless of which version of the CMS 2552 was filed by the hospital.**

SCHEDULE A

MISCELLANEOUS REVENUES

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

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

SCHEDULE B

COST DISTRIBUTION

__Column 1__
Lines 30-46, 50-132, and 201 - Enter total cost figures from Worksheet C, Part I, column 5 for each revenue center. **Note: Report costs for Organ Acquisition, Hospice, and Home Health Agency from Worksheet B, part I, column __For free-standing psychiatric hospitals, do not report costs associated with residential treatment.__**

Line 201 - Enter Observation Bed costs only if these costs are included both on line 30 and on line 92.

__Column 2__
Lines 30-46 and 50-132 - Enter all Interns and Residents costs that were removed from total cost reported on Worksheet B part I, column 26. Include drug costs related to Renal Dialysis or Home Program Dialysis that were also removed from total costs.

__Column 3__
Lines 30 - 132 - Enter the total of columns 1 and 2.

__Column 4__
For any revenue center that has costs but no corresponding charges, enter a charge of one dollar ($1.00).

Lines 30-132 - Record total charges from Worksheet C, part I, column 8.

Line 201 - Enter one dollar ($1.00) if an amount is entered in column 3, line 201.

__Column 5__
Lines 30-46, 50-132, and 201 - Divide each line amount in column 3 by the corresponding line amount in column 4 and enter the result rounded to six decimal places.

__Column 6__
Lines 30-46 and 50-132 - Enter the total allowable inpatient charges from Worksheet C, part I, column 6 for each revenue center. (**Note:** Subprovider services reimbursed on a cost basis by Medicare but reimbursed by Medicaid on the DRG system **must** be included in this column; i.e., Distinct Part Psychiatric services. **Do not enter data for those revenue centers not eligible for cost reimbursement or DRG payment, e.g. Home Health Agency, SNF, Hospice, Ambulance, residential treatment).**

Line 201 - __If Observation Bed costs are reported on line 92 and included in line 30, enter one dollar ($1.00).__

__Column 7__
Lines 30-46, 50-132, and 201 - Multiply the charges in column 6 by the corresponding ratio in column 5. Enter the result rounded to the nearest dollar.

__Column 8__
Lines 30-46 and 50-132 - Enter the total allowable outpatient charges from Worksheet C, part I, column 7 for each revenue center. **Do not include amounts for those revenue centers previously not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.**

Column 9
Lines 30-46 and 50-132 - Multiply the charges in column 8 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

Column 10
Lines 30-46 and 50-132 - Enter charges for revenue centers that are not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.

Column 11
Lines 30-46 and 50-132 - Multiply the charges in column 10 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

Columns 1-11
Line 49 - Enter the total of lines 30 through 46.

Line 199 - Enter the total of lines 50 through 132.

Line 200 - Enter the total of lines 49 and 199.

Line 202 - Enter the total of line 200 less line 201.

(Line 202, Col. 4 must equal the sum of cols. 6, 8, & 10.)
Be sure to foot and cross-foot all columns.

SCHEDULE C

CALCULATION OF ROUTINE COSTS

Column 1 - Transfer amounts from Schedule B, column 7, lines 30-46 to the appropriate lines. Enter the sum of lines 30-46 on line 49.

Column 2 - Swing Beds - Transfer to line 30 the amount on Worksheet D-1, part I, line 26 as negative amounts. Enter the sum of lines 30-46 on line 49.

Column 3 - For each line enter the sum of columns 1 and 2. Enter the sum of lines 30-46 on line 49.

Column 4 - Enter the total days from Worksheet S-3, part I, column 8 to the appropriate lines. **If there are Observation Bed days reported on Worksheet S-3, line 26, column 6, or Employee Discount Days reported on Worksheet S-3, line 28, column 6, include these days in Adult & Pediatric, line 30. For Observation Bed days assigned directly to a subprovider, those days should be included with the subprovider's days rather than in Adults & Pediatric, line 30.** Do not include swing bed days. **For free-standing psychiatric hospitals, do not include residential treatment days**. Enter the sum of lines 30-46 on line 49.

Column 5 - Divide each line amount in column 3 by the corresponding days in column 4 for lines 30-46 and enter the result rounded to two decimal places.

Column 6 - For each revenue center, enter the number of covered days of service rendered to Title XIX patients discharged during the reporting period. **Do not include Observation Bed days or non-covered days (e.g., swing bed, patients age 22-64 in free-standing psychiatric hospitals). Include transplant services that are paid on a DRG basis. (Do not include transplant services paid on a reasonable cost basis).** Enter the sum of lines 30-46 on line 49.

Column 7 - For each revenue center, multiply the per diem calculated in column 5 by the XIX days reported in column 6 and enter the result rounded to the nearest dollar. Enter the sum of lines 30-46 on line 49.

Column 8 - For each revenue center, enter the number of covered days of service rendered to Title V patients discharged during the reporting period. **Do not include Observation Bed days or non-covered days.** Enter the sum of lines 30-46 on line 49.

Column 9 - For each revenue center, multiply the per diem calculated in column 5 by the Title V days reported in column 8 and enter the result rounded to the nearest dollar. Enter the sum of lines 30-46 on line 49.

Column 10 - For each revenue center, enter the number of covered days of service rendered to Title XIX transplant patients discharged during the reporting period. **Include only transplant services paid on a reasonable cost basis. Do not include Observation Bed days, non-covered days, or transplant services paid by DRG.** Enter the sum of lines 30-46 on line 49.

Column 11 - For each revenue center, multiply the per diem calculated in column 5 by the Title XIX transplant days reported in column 10 and enter the result rounded to the nearest dollar. Enter the sum of lines 30-46 on line 49.

SCHEDULE C-1

DISCHARGE STATISTICS

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

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

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

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

SECTION I

<u>**Column 1**</u> **-** Enter, from Worksheet S-3, part I, column 15, the number of discharges for each revenue center. Enter the sum of lines 50-53 on line 54. **Although Total Facility Nursery Discharges are not detailed on Worksheet S-3, part I, please report Total Facility Nursery Discharges as maintained in your records.**

<u>**Columns 2-4**</u> **-** Enter the number of discharges from the facility for program patients. Title XIX services are classified by various rate years. Your fiscal year may not include every category. Only report discharges into the category that corresponds with your fiscal year. Enter the sum of each column on line 54.

- <u>**Include in columns 2 and 3 any discharges for transplant services that are paid on a DRG basis. Any transplant services that are not reimbursed on a DRG basis should be reported in column 5.**</u>
- <u>**When reporting days in section I, lines 40, 41 or 43, be sure to report corresponding discharges in section I, lines 51, 52 & 53.**</u>

<u>**Column 2-4, line 55**</u> **-** Enter your capital add-on rate for the periods for which you reported discharges.

<u>**Columns 7 & 8**</u> - Enter the number of discharges from the facility for Medicaid HMO enrolled patients. Medicaid HMO services are classified by various rate years. Your fiscal year may not include every category. Only report discharges into the category that corresponds with your fiscal year. Enter the sum of each column on line 54.

- <u>**When reporting days in Schedule C-2, section I, lines 40, 41 or 43, be sure to report corresponding discharges in section I, lines 51, 52 & 53.**</u>

SECTION II

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

Line 56, column 1 – Enter the number of total facility outpatient visits.

Line 56, column 2 – Enter the number of Medicaid outpatient visits on or before 12/31/10.

Line 56, column 3 – Enter the number of Medicaid outpatient visits on or after 1/1/11.

SECTION III

Line 57 - Enter as a sum, the number of beds on Worksheet S-3, part I, column 1, lines 12 and 14.

Line 58 - Enter as a sum, the net number of interns and residents in an approved teaching program on Worksheet S-3, part I, column 9, lines 12, and 14.

SCHEDULE C-2

MEDICAID HMO INPATIENT DAYS

SECTION I

Column 1 – Enter the per diem amounts from Schedule C, column 5, for each cost center in Lines 30 – 46.

Column 2 – For each revenue center, enter the number of covered days of service rendered to Medicaid HMO patients discharged during the reporting period. Enter the sum of lines 30 - 46 on line 49.

Column 3 – For each revenue center, multiply the per diem calculated in column 1 by the Medicaid HMO days reported in column 2 and enter the result rounded to the nearest dollar. Enter the sum of lines 30 - 46 on line 49.

SCHEDULE D

TITLE XIX COST CALCULATIONS

Include charges for the following;

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

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

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

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

Column 2
Lines 30-46 and 50-132 - Enter the charges for covered Title XIX inpatient services rendered during the reporting period. **Include transplant services that are reimbursed on a DRG basis.**

Column 3
Lines 30-46 - Transfer the cost amounts from Schedule C, column 7, lines 30-46.

Lines 50-132 - Multiply the charges in column 2 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 4
Lines 30-46 - Enter charges for covered outpatient services only if outpatient charges are also reported on Schedule B.

Lines 50 -132 - Enter the charges for covered outpatient services. **Do not include charges for Outpatient Laboratory Services, or any services which are not cost settled, (e.g., Pregnancy services).**

Column 5
Lines 30-46 and 50 -132 - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 6
Lines 60 and 106 - 132 - Enter the charges for Outpatient Laboratory Services.

Column 7

Lines 60 and 106 - 132 - Multiply the charges in column 6 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 8

Lines 30-46 and 50-132 - Report only allowable charges for transplant services that are reimbursed on a reasonable cost basis during the reporting period.

Column 9

Lines 30-46 - Transfer the cost amounts from Schedule C, column 11, lines 30-46.

Lines 50-132 - Multiply the charges in column 8 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Columns 2-5 and 8-9

Line 49 - Enter the total of lines 30 through 46.

Line 199 - Enter the total of lines 50 through 132.

Line 200 - Enter the total of lines 49 and 199.

SCHEDULE D-1

TITLE V COST CALCULATIONS

Column 1
Lines 30-46 and 50-132 - Transfer total cost amounts from Schedule B, column 3, to the corresponding lines.

Column 2
Lines 30-46 and 50-132 - Enter the amount of cost associated with combined billing of provider based physician professional services as reported on Worksheet A-8-2, column 4.

Column 3
Lines 30-46 and 50-132 - Enter the sum of columns 1 and 2.

Column 4
Lines 30-46 and 50-132 - Transfer the total charge amounts from Schedule B, column 4, to the corresponding lines.

Column 5
Lines 30-46 and 50-132 - Enter the amount of charges associated with the costs of combined billing of provider based physician professional services that are reported in column 2.

Column 6
Lines 30-46 and 50-132 - Enter the sum of columns 4 and 5.

Column 7
Lines 30-46 and 50-132 - Divide column 3 by column 6 and enter the resulting ratio, rounded to six decimal places, for each cost center.

Column 8
Lines 30-46 and 50-132 - Enter the charges for covered inpatient Title V services rendered during the cost reporting period.

Column 9
Lines 30-46 - Transfer the cost amounts from Schedule C, column 9.

Lines 50-132 - Multiply the charges in column 8 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

Column 10
Lines 30-46 and 50-132 - Enter the charges **(including Outpatient Laboratory and Radiology services for covered outpatient Title V services) rendered during the reporting period.**

Column 11
Lines 30-46 and 50-132 - Multiply the charges in column 10 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

Columns 1-11
Line 49 - Enter the total of lines 30 through 46.

Line 199 - Enter the total of lines 50 through 132.

Line 200 - Enter the total of lines 49 and 199.

SCHEDULE E

MEDICAL EDUCATION COSTS AND MISCELLEANOUS DATA

MEDICAL EDUCATION COSTS

Line 1 – Enter the amount from Worksheet B, part **I**, column 20 – 20.XX, line 95.
Line 2 – Enter the amount from Worksheet B, part **I**, column 21 – 21.XX, line 95.
Line 3 – Enter the amount from Worksheet B, part **I**, columns 22 – 22.XX and 23 – 23.XX, line 95.
Line 4 – Enter the amount from Worksheet B, part **I**, column 24 – 24.XX, line 95.
Line 5 – Enter the total of lines 1 through 4.

XIX OUTPATIENT LAB PAYMENTS

Line 6 - Enter the total Title XIX Outpatient Lab payments received that relate to charges reported on Schedule D, column 6, line 60 or other Lab cost centers indentified on lines 106 - 132.

NET PATIENT REVENUES | SECTION 1011 PAYMENTS

Line 7a – Enter the Net Patient Revenue amount from Worksheet G-3 line 3.
Line 7b – Enter the amount received for services provided under Section 1011 – Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. For additional information regarding Section 1011, please visit the following websites; http://www.trailblazerhealth.com/Section_1011/Default.aspx? or http://www.cms.hhs.gov/MLNProducts/downloads/Section_1011_Fact_Sheet.pdf

SCHEDULE F

HOSPITAL CARE ASSURANCE UNCOMPENSATED CARE

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

INDEPENDENT THIRD PARTY VALIDATION OF SCHEDULE F DATA

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

1. Verify that patient logs are maintained for the following categories of patients:
    - Disability Assistance inpatient charges, with insurance
    - Uncompensated care inpatient charges < 100% federal poverty income limits (FPL), with insurance
    - Disability Assistance outpatient charges, with insurance
    - Uncompensated care outpatient charges < 100% FPL, with insurance
    - Disability Assistance inpatient charges, with no insurance
    - Uncompensated care < 100% FPL, inpatient charges, with no insurance
    - Uncompensated care > 100% FPL, inpatient charges, with no insurance
    - Disability Assistance outpatient charges, with no insurance
    - Uncompensated care < 100% FPL, outpatient charges, with no insurance
    - Uncompensated care > 100% FPL, outpatient charges, with no insurance

2. Verify that the Hospital's patient logs include a date-of-service. Verify that the service dates for accounts with Disability Assistance coverage or family income < 100% FPL are recorded in the cost report period in which they occurred, and that the write-off dates for accounts with family incomes >100% FPL, are recorded in the cost report period in which they were written-off. Verify that each log entry includes a unique (unduplicated) identifier for the patient, that is unique to the patient and not to each visit by the patient.

3. Verify that the supporting patient log totals for the data elements listed below agree to each data element on the Hospital's JFS 02930 Schedule F. If any of the elements do not match, return the patient logs to Hospital for correction.
    - Line 8, Columns 1 and 6 – Disability Assistance inpatient charges and receipts, with insurance
    - Line 9, Columns 1 and 6 – Uncompensated care < 100% FPL inpatient charges and receipts , with insurance
    - Line 12, Columns 1 and 6 – Disability Assistance, outpatient charges and receipts, with insurance
    - Line 13, Columns 1 and 6 – Uncompensated care < 100% FPL, outpatient charges and receipts, with insurance
    - Line 8, Columns 2 and 7 – Disability Assistance, inpatient charges and receipts, with no insurance
    - Line 9, Columns 2 and 7 – Uncompensated care < 100% FPL, inpatient charges and receipts , with no insurance
    - Line 10, Columns 2 and 7 – Uncompensated care > 100% FPL, inpatient charges and receipts, with no insurance
    - Line 12, Columns 2 and 7 – Disability Assistance outpatient charges and receipts, with no insurance
    - Line 13, Columns 2 and 7 – Uncompensated care < 100% FPL, outpatient charges and receipts, with no insurance
    - Line 14, Columns 2 and 7 – Uncompensated care > 100% FPL, outpatient charges and receipts, with no insurance

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

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

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

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

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

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

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

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

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

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

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

Hospital Response to External Reviewer Report

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

Re-verification of Schedule F Changes

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

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

External Data Validation Report

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

GENERAL INSTRUCTIONS (APPLIES TO ALL OF SECTION I):

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

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

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

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

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

SECTION I (UNCOMPENSATED CARE FOR ACUTE CARE HOSPITALS)

Instructions for Column 1

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

GROSS INPATIENT CHARGES

Line 8: Total DA Charges for Patients with Insurance - INPATIENT
Enter the gross charges for inpatient discharges by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F1, column 2.

Line 9: Total UC Charges for Patients Below 100% with Insurance - INPATIENT
Enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F2, column 2.

Line 10: Total UC Charges for Patients Above 100% with Insurance - INPATIENT
Enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines, and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F. Please enter cost center detailed charges for these patients on Schedule F3, column 2.

Line 11: Total Uncompensated Care Charges for Patients with Insurance - INPATIENT
Enter the total of lines 8 through 10.

GROSS OUTPATIENT CHARGES

Line 12: Total DA Charges for Patients with Insurance – OUTPATIENT
Enter the gross charges for outpatient visits by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F1, column 4.

Line 13: Total UC Charges for Patients Below 100% with Insurance – OUTPATIENT
Enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F2, column 4.

Line 14: Total UC Charges for Patients Above 100% with Insurance – OUTPATIENT
Enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year.

Recipients of Medicaid in any other state can not be included of Schedule F. Please enter cost center detailed charges for these patients on Schedule F3, column 4.

Line 15: Total Uncompensated Care Charges for Patients with Insurance – OUTPATIENT
Enter the total of lines 12 through 14.

INPATIENT DISCHARGES

Line 16: Total DA Inpatient Discharges for Patients with Insurance
Enter the number of inpatient discharges for Disability Assistance patients who also had some form of insurance for the services delivered during your hospital's fiscal year.

Line 17: Total UC Inpatient Discharges for Patients Below 100% with Insurance
Enter the number of inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

Line 18: Total UC Inpatient Discharges for Patients Above 100% with Insurance
Enter the number of inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 19: Total UC Inpatient Discharges for Patients with Insurance
Enter the total of lines 16 through 18.

OUTPATIENT VISITS

Line 20: Total DA Outpatient Visits for Patients with Insurance
Enter the number of outpatient visits for Disability Assistance patients who also had some form of insurance for the services delivered, during your hospital's fiscal year.

Line 21: Total UC Outpatient Visits for Patients Below 100% with Insurance
Enter the number of outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

Line 22: Total UC Outpatient Visits for Patients Above 100% with Insurance
Enter the number of outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 23: Total UC Outpatient Visits for Patients with Insurance
Enter the total of lines 20 through 22.

Instructions for Column 2

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

GROSS INPATIENT CHARGES

Line 8: Total DA Charges for Patients without Insurance – INPATIENT
Enter the gross charges for inpatient discharges by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F1, column 6.

Line 9: Total UC Charges for Patients Below 100% without Insurance – INPATIENT
Enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F2, column 6.

Line 10: Total UC Charges for Patients Above 100% without Insurance – INPATIENT
Enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F. Please enter cost center detailed charges for these patients on Schedule F3, column 6.

Line 11: Total Uncompensated Care Charges for Patients without Insurance – INPATIENT
Enter the total of lines 8 through 10.

GROSS OUTPATIENT CHARGES

Line 12: Total DA Charges for Patients without Insurance – OUTPATIENT
Enter the gross charges for outpatient visits by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F1, column 8.

Line 13: Total UC Charges for Patients Below 100% without Insurance – OUTPATIENT
Enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year. Please enter cost center detailed charges for these patients on Schedule F2, column 8.

Line 14: Total UC Charges for Patients Above 100% without Insurance – OUTPATIENT
Enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F. Please enter cost center detailed charges for these patients on Schedule F2, column 8.

Line 15: Total Uncompensated Care Charges for Patients without Insurance – OUTPATIENT
Enter the total of lines 12 through 14.

INPATIENT DISCHARGES

Line 16: Total DA Inpatient Discharges for Patients without Insurance
Enter the number of inpatient discharges for Disability Assistance patients who did not have insurance for the services delivered during your hospital's fiscal year.

Line 17: Total UC Inpatient Discharges for Patients Below 100% without Insurance
Enter the number of inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the

Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

<u>Line 18:</u> Total UC Inpatient Discharges for Patients Above 100% without Insurance
Enter the number of inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state cannot be included.

<u>Line 19:</u> Total UC Inpatient Discharges for Patients without Insurance
Enter the total of lines 16 through 18.

OUTPATIENT VISITS

<u>Line 20:</u> Total DA Outpatient Visits for Patients without Insurance
Enter the number of outpatient visits for Disability Assistance patients who did not have insurance for the services delivered, during your hospital's fiscal year.

<u>Line 21:</u> Total UC Outpatient Visits for Patients Below 100% without Insurance
Enter the number of outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

<u>Line 22:</u> Total UC Outpatient Visits for Patients Above 100% without Insurance
Enter the number of outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

<u>Line 23:</u> Total UC Outpatient Visits for Patients without Insurance
Enter the total of lines 20 through 22.

Instructions for Column 3

<u>COLUMN 3</u> Column 3 includes the Medicaid inpatient and outpatient cost to charge ratios for your hospital.

<u>Lines 8, 9, 10, and 11:</u> Inpatient Cost to Charge Ratio
Divide the sum of the values in column 3, line 101, of Schedule D and column 3, line 101, of Schedule I by the sum of the values in column 2, line 101, of Schedule D and column 2, line 101, of Schedule I to calculate the inpatient cost to charge ratio.

<u>Lines 12, 13, 14, and 15:</u> Outpatient Cost to Charge Ratio
Divide the sum of the values in column 5, line 101, of Schedule D and column 5, line 101, of Schedule I by the sum of the values in column 4, line 101, of Schedule D and column 4, line 101, of Schedule I to calculate the outpatient cost to charge ratio.

Instructions for Columns 4 and 5

Calculation of Uncompensated Care Costs for Patients with Insurance

<u>Lines 8 through 15:</u> Column 4
Multiply the value in column 1 by the value in column 3 for each line and subtract the value in column 6.

<u>Lines 8 through 15:</u> Column 5
Multiply the value in column 2 by the value in column 3 for each line and subtract the value in column 7.

Instructions for Column 6

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

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

<u>Line 8:</u> Total DA Receipts for Patients with Insurance – INPATIENT
Enter the receipts for inpatient discharges by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

<u>Line 9:</u> Total UC Receipts for Patients Below 100% with Insurance – INPATIENT
Enter the receipts for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

<u>Line 10:</u> Total UC Receipts for Patients Above 100% with Insurance – INPATIENT
Enter the receipts for inpatient discharges for patients with family incomes above the federal poverty income guidelines, and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 11: Total Inpatient Uncompensated Care Receipts for Patients with Insurance – INPATIENT
Enter the total of lines 8 through 10.

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

<u>Line 12:</u> Total DA Receipts for Patients with Insurance – OUTPATIENT
Enter the receipts for outpatient visits by eligible Disability Assistance recipients, who also had some form of insurance for the services delivered, during your hospital's fiscal year.

<u>Line 13:</u> Total UC Receipts for Patients Below 100% with Insurance – OUTPATIENT
Enter the receipts for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year.

<u>Line 14:</u> Total UC Receipts for Patients Above 100% with Insurance – OUTPATIENT
Enter the receipts for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state can not be included of Schedule F.

<u>Line 15:</u> Total Uncompensated Care Receipts for Patients with Insurance – OUTPATIENT

Enter the total of lines 12 through 14.

UNDUPLICATED INPATIENT DISCHARGES

Line 16: Total DA Unduplicated Inpatient Discharges for Patients with Insurance
Enter the number of unduplicated inpatient discharges for Disability Assistance patients who also had some form of insurance for the services delivered during your hospital's fiscal year.

Line 17: Total UC Unduplicated Inpatient Discharges for Patients Below 100% with Insurance
Enter the number of unduplicated inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

Line 18: Total UC Unduplicated Inpatient Discharges for Patients Above 100% with Insurance
Enter the number of unduplicated inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 19: Total UC Unduplicated Inpatient Discharges for Patients with Insurance
Enter the total of lines 16 through 18.

UNDUPLICATED OUTPATIENT VISITS
Line 20: Total DA Unduplicated Outpatient Visits for Patients with Insurance
Enter the number of unduplicated outpatient visits for Disability Assistance patients who also had some form of insurance for the services delivered, during your hospital's fiscal year.

Line 21: Total UC Unduplicated Outpatient Visits for Patients Below 100% with Insurance
Enter the number of unduplicated outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the service delivered, during your hospital's fiscal year.

Line 22: Total UC Unduplicated Outpatient Visits for Patients Above 100% with Insurance
Enter the number of unduplicated outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which had some form of insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 23: Total UC Unduplicated Outpatient Visits for Patients with Insurance
Enter the total of lines 20 through 22.

Instructions for Column 7

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

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

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

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

<u>Line 9:</u> Total UC Receipts for Patients Below 100% without Insurance – INPATIENT
Enter the receipts for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

<u>Line 10:</u> Total UC Receipts for Patients Above 100% without Insurance – INPATIENT
Enter the receipts for inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

<u>Line 11:</u> Total Uncompensated Care Receipts for Patients without Insurance – INPATIENT
Enter the total of lines 8 through 10.

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

<u>Line 12:</u> Total DA Receipts for Patients without Insurance – OUTPATIENT
Enter the receipts for outpatient visits by eligible Disability Assistance recipients, who did not have insurance for the services delivered, during your hospital's fiscal year.

<u>Line 13:</u> Total UC Receipts for Patients Below 100% without Insurance – OUTPATIENT
Enter the receipts for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year.

<u>Line 14:</u> Total UC Receipts for Patients Above 100% without Insurance – OUTPATIENT
Enter the receipts for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

<u>Line 15:</u> Total Uncompensated Care Receipts for Patients without Insurance – OUTPATIENT
Enter the total of lines 12 through 14.

UNDUPLICATED INPATIENT DISCHARGES

<u>Line 16:</u> Total DA Unduplicated Inpatient Discharges for Patients without Insurance
Enter the number of unduplicated inpatient discharges for Disability Assistance patients who did not have insurance for the services delivered during your hospital's fiscal year.

<u>Line 17:</u> Total UC Unduplicated Inpatient Discharges for Patients Below 100% without Insurance
Enter the number of unduplicated inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

<u>Line 18:</u> Total UC Unduplicated Inpatient Discharges for Patients Above 100% without Insurance

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

Line 19: Total UC Unduplicated Inpatient Discharges for Patients without Insurance
Enter the total of lines 16 through 18.

UNDUPLICATED OUTPATIENT VISITS

Line 20: Total DA Unduplicated Outpatient Visits for Patients without Insurance
Enter the number of unduplicated outpatient visits for Disability Assistance patients who did not have insurance for the services delivered, during your hospital's fiscal year.

Line 21: Total UC Unduplicated Outpatient Visits for Patients Below 100% without Insurance
Enter the number of unduplicated outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the service delivered, during your hospital's fiscal year.

Line 22: Total UC Unduplicated Outpatient Visits for Patients Above 100% without Insurance
Enter the number of unduplicated outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, which did not have insurance for the services delivered, but were either unable or unwilling to pay for some portion of the bill, and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included on Schedule F.

Line 23: Total UC Unduplicated Outpatient Visits for Patients without Insurance
Enter the total of lines 20 through 22.

SECTION II (FREE-STANDING PSYCHIATRIC HOSPITAL INFORMATION)

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

Column 1: Payments from Insurance
Enter payments received for psychiatric hospital inpatient services billed to and received from all sources other than the self-pay revenues in Column 2 and Ohio Medicaid payments reported on Schedule H.

Column 2: Payments from Self-Pay
Enter payments received for psychiatric hospital inpatient services billed to and received from either the person who received inpatient psychiatric services or the family of the person that received inpatient psychiatric service.

Column 3: Charges for Charity Care
Enter the total charges for psychiatric hospital services provided to indigent patients. This includes charges for services provided to individuals who do not possess health insurance for the services provided. However, this does not include bad debts, contractual allowances or uncompensated care costs rendered to patients with insurance where the full cost of service was not reimbursed because of per diem caps or coverage limitations.

Column 4: Government Cash Subsidies Received
Enter the amount of cash subsidies received directly from state and local governments for psychiatric hospital inpatient services.

<u>Column 5:</u> Uncompensated Care Costs for Patients with Insurance
Enter the psychiatric hospital inpatient costs for individuals that have insurance coverage for the service provided, but full reimbursement was not received due to per diem caps or coverage limitations.

<u>Column 6:</u> Medicaid Days Provided to Medicaid Recipients Age 21 and Under
Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 21 and under who were discharged during the hospital's fiscal year.

<u>Column 7:</u> Medicaid Days Provided to Medicaid Recipients Age 22 to Age 64
Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 22 to age 64 who were discharged during the hospital's fiscal year.

<u>Column 8:</u> Medicaid Days Provided to Medicaid Recipients Age 65 and Over
Enter the total psychiatric hospital inpatient days provided to Ohio Medicaid recipients age 65 and over who were discharged during the hospital's fiscal year.

SCHEDULE F1

DISABILITY ASSISTANCE - DETAIL

<u>Column 1</u> - Enter the ratio from Schedule B, column 5, for each cost center on the corresponding line.

Column 2 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for inpatient discharges eligible for Disability Assistance recipients, who had some form of insurance for the services provided. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 8.

Column 3 – for each cost center multiply the amount in Column 2 by the ratio in Column 1.

Column 4 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for outpatient visits eligible for Disability Assistance recipients, who had some form of insurance for the services provided. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 12.

Column 5 – for each cost center multiply the amount in Column 4 by the ratio in Column 1.

Column 6 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for inpatient discharges eligible for Disability Assistance recipients, who did not have insurance for the services provided. This column is the charge detail to support the amount entered on Schedule F, Column 2, Line 8.

Column 7 – for each cost center multiply the amount in Column 6 by the ratio in Column 1.

Column 8 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for outpatient visits eligible for Disability Assistance recipients, who did not have insurance for the services provided. This column is the charge detail to support the amount entered on Schedule F, Column 2, Line 12.

Column 9 – for each cost center multiply the amount in Column 8 by the ratio in Column 1.

Line 49 – Columns 2 – 9 enter the sum of Lines 30 – 46.

Line 199 – Columns 2 – 9 enter the sum of Lines 50 – 132.

Line 202 – Columns 2 – 9 enter the total of Line 50 plus Line 199.

Line 204 – Columns 2, 4, 6 & 8 enter receipts received for charges in same column. Columns 3, 5, 7 & 9 subtract the amount in the preceding column from costs in Line 202 of the same column.

SCHEDULE F2

UNCOMPENSATED CARE < 100% - DETAIL

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

Column 2 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, during your hospital's fiscal year. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 9.

Column 3 – for each cost center multiply the amount in Column 2 by the ratio in Column 1.

Column 4 – Lines 33 – 46 and 50 – 132, for each cost center, Enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 13.

Column 5 – for each cost center multiply the amount in Column 4 by the ratio in Column 1.

Column 6 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for inpatient discharges for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year. This column is the charge detail to support the amount entered on Schedule F, Column 2, Line 9.

Column 7 – for each cost center multiply the amount in Column 6 by the ratio in Column 1.

Column 8 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for outpatient visits for patients not covered by Disability Assistance, with family incomes at or below the federal poverty income guidelines, who qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who did not have insurance for the services delivered, during your hospital's fiscal year. This column is the charge detail to support the amount entered on Schedule F, Column 2, Line 13.

Column 9 – for each cost center multiply the amount in Column 8 by the ratio in Column 1.

Line 49 – Columns 2 – 9 enter the sum of Lines 30 – 46.

Line 199 – Columns 2 – 9 enter the sum of Lines 50 – 132.

Line 202 – Columns 2 – 9 enter the total of Line 50 plus Line 199.

SCHEDULE F3

UNCOMPENSATED CARE > 100% - DETAIL

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

Column 2 – Lines 33 – 46 and 50 – 132, for each cost center, Enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines, and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code and who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 10.

Column 3 – for each cost center multiply the amount in Column 2 by the ratio in Column 1.

Column 4 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state can not be included. This column is the charge detail to support the amount entered on Schedule F, Column 1, Line 14.

Column 5 – for each cost center multiply the amount in Column 4 by the ratio in Column 1.

Column 6 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for inpatient discharges for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of the Ohio Administrative Code, who did not have insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any state can not be included. This column is charge detail to support the amount entered on Schedule F, Column 2, Line 10.

Column 7 – for each cost center multiply the amount in Column 6 by the ratio in Column 1.

Column 8 – Lines 33 – 46 and 50 – 132, for each cost center, enter the gross charges for outpatient visits for patients with family incomes above the federal poverty income guidelines and all others who do not qualify for free care under rule 5101:3-2-07.17 of The Ohio Administrative Code, who had some form of insurance for the services delivered, but were either unable or unwilling to pay for a portion of the bill and which were written off during your hospital's fiscal year. Recipients of Medicaid in any other state can not be included. This column is charge detail to support the amount entered on Schedule F, Column 2, Line 14.

Column 9 – for each cost center multiply the amount in Column 8 by the ratio in Column 1.

Line 49 – Columns 2 – 9 enter the sum of Lines 30 – 46.

Line 199 – Columns 2 – 9 enter the sum of Lines 50 – 132.

Line 202 – Columns 2 – 9 enter the total of Line 50 plus Line 199.

SCHEDULE G

TITLE XIX CAPITAL RELATED COST REIMBURSEMENT

DRG EXEMPT HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.

Column 1
Lines 30-46 and 50-132 - For each revenue center, transfer the total charges from Schedule B, column 4, lines 30 through 46, and 50 through 132.

Column 2
Lines 30-46 and 50-132 - For each revenue center, enter the old capital related cost from Worksheet B, Part II, column 25, and the new capital related cost from Worksheet B, Part III, column 25.. The total of this column should be the sum of old capital costs and new capital costs combine.

Column 3
Reserved for Future Use

Column 4
Lines 30-46 and 50-132 - Enter the sum of columns 2 and 3.

Column 5
Lines 30-46 and 50-132 - Divide column 4 by column 1. Enter the result rounded to six decimal places.

Column 6
Lines 30-46 and 50-132 - Enter the charge amounts from Schedule D, column 2.

Column 7
Lines 30-46 and 50-132 - For each revenue center, multiply column 6 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

Line 201 - Multiply the capital add-on rates in effect for the cost reporting period by the total number of XIX inpatient discharges on Schedule C-1, columns 2 and 3, line 54.

Columns 1-7
Line 49 - Enter the total of lines 30 through 46.

Line 199 - Enter the total of lines 50 through 132.

Line 200 - Enter the total of lines 49 and 199.

Column 7
Line 202 - Enter the result of line 201 less line 200.

SCHEDULE H

SETTLEMENT SUMMARY

<u>**Section I**</u> **INPATIENT SERVICES**

Line 1, columns 1-3 - Transfer amounts from Schedule D, column 3, line 202; Schedule D-1, column 9, line 202; and Schedule D, column 9, line 202, into the appropriate column.

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

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

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

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

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

Line 6, column 1 - Enter amount due Program/(Provider), **using the opposite sign,** from Schedule G, column 7, line 202. *DRG-exempt and out-of-state hospitals, enter 0.*

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

Line 8, columns 1-3 - Transfer amounts from Schedule D, column 2, line 202; Schedule D-1, column 8, line 202; and Schedule D, column 8, line 202, into the appropriate column.

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

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

<u>*CONTINUE TO SECTION II*</u>

<u>**Section II**</u> **OUTPATIENT SERVICES**

Line 10, columns 1-2 - Transfer amounts from Schedule D, column 5, line 202 and Schedule D-1, column 11, line 202 into the appropriate columns.

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

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

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

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

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

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

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

Line 16, columns 1-2 - Enter amounts from Schedule D, column 4, line 202 and Schedule D-1, column 10, line 202.

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

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

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

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

CONTINUE TO SECTION IV, LINE 28

Section III SETTLEMENT TEST

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

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

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

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

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

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

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

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

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

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

<u>Section IV</u> PROGRAM(S) SUMMARY

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

Line 27, column 1 - Enter the amount from Schedule G, column 7, line 202. *DRG-exempt hospitals, enter 0.*

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

SCHEDULE I

TITLE XIX HMO COST CALCULATIONS

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

Include charges for the following;

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

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

SECTION I

<u>Column 1</u>
Lines 30-46 and 50-132 - Enter the ratio from Schedule B, column 5 for each revenue center on the corresponding lines.

<u>Column 2</u>
Lines 30-46 and 50-132 - Enter the charges for Title XIX covered inpatient services rendered during the reporting period.

<u>Column 3</u>
Lines 30-46 and 50-132 - Multiply the charges in column 2 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

<u>Column 4</u>
Lines 30-46, 50-60, and 61-132 - Enter the charges for Title XIX covered outpatient services. **Do not include charges for Outpatient Laboratory Services.**

<u>Column 5</u>
Lines 30-46, 50-60, and 61-132 - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 6 – This column is reserved.

Column 7
Lines 30-46 and 50-132 - Enter the ratio from Schedule G, column 5, for each revenue center on the corresponding line.

Column 8
Lines 30-46 and 50-132 - Multiply the charges in column 2 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

Line 203 - Multiply the capital add-on rates in effect for the cost reporting period by the total number of Medicaid HMO inpatient discharges on Schedule C-1, columns 7 and 8, line 54.

Columns 2-8

Line 49 - Enter the total of lines 30 through 46.

Line 199 - Enter the total of Lines 50 through 132.

Line 200 - Enter the total of lines 49 and 199.

SECTION II

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

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

Line 204, column 2 - Enter the total XIX inpatient HMO days Schedule C-2, Column 2, Line 49.

Line 204, column 4 - Enter the total XIX outpatient HMO visits.

Line 205, column 2 – Enter the total facility inpatient HMO days.

Line 205, column 4 – Enter the total facility outpatient HMO visits.

Line 206, column 2 - Enter the total XIX inpatient HMO discharges Schedule C-1, column 7, line 40 plus Schedule C-1, column 8, line 40.

Line 207, column 2 – Enter the total facility inpatient HMO discharges.

Line 208 Report all amounts received or receivable as payment for the charges reported in Section I. Include all amounts received or receivable from Ohio Medicaid Managed Care Plans directly as well as those amount received or receivable from other payers (Blue Cross, Aetna, Railroad, etc) for Ohio Medicaid Managed Care enrollees.

Line 208, column 2 – Enter the total XIX inpatient HMO payments.

Line 208, column 4 – Enter the total XIX outpatient HMO payments.

Ohio Department of Job and Family Services

HOSPITAL COST REPORT
STATE FISCAL YEAR 2011
CERTIFICATION BY OFFICER OF HOSPITAL

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

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

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

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

for the cost reporting period beginning and ending , and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions and regulations including independent certification of Schedule F, and the accuracy of the OBRA Survey, except as noted.

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

Name of Individual Report Was Prepared By	Title

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

OBRA SURVEY

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

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

Section A

Question	Answer: YES	NO	N/A
1 Does your hospital predominantly serve patients less than 18 years of age? (If answer to this question is Yes, please proceed to Section B.)	○	○	
2 As of December 22, 1987, did your hospital offer non-emergency obstetric services to the general population? (If answer to this question is No, please proceed to Section B, if Yes answer question 3.)	○	○	○
3 Does your hospital currently offer non-emergency obstetric services to the general population? (If answer to this question is Yes, please proceed to Section B.)	○	○	○

4 Answer the one question below appropriate to your hospital. If your hospital is deemed a rural hospital for purposes of Medicare reimbursement, answer question (a). If your hospital is an urban hospital for purposes of Medicare reimbursement, answer question (b).

Question	YES	NO	N/A
a Rural: Does your hospital have at least two physicians (may or may not be obstetricians) with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? **If you responded No, please explain below**.	○	○	○
b Urban: Does your hospital have at least two obstetricians with staff privileges who have agreed to provide non-emergency obstetric services to Medicaid recipients? **If you responded No, please explain below**.	○	○	○

Section B

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

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

(1) the fraction, expressed as a percentage:

(a) the numerator of which is the sum for a period of Medicaid (Ohio only) revenues (payments including HMO payments for patient services plus the amount of cash subsidies (including HCAP and UPL payments) for patient services received directly from state and local governments.

(b) the denominator of which is the total patient services revenue -- including such cash subsidies -- for the period.

(2) the fraction, expressed as a percentage:

(a) the numerator of which is the total (gross) hospital inpatient charges in a period attributable to charity care (not including contractual allowances and discounts and bad debts) less the portion of any subsidies received in the period from state and local governments reasonably attributed to inpatient hospital services.

(b) the denominator of which is total (gross) hospital inpatient charges in the period.

Provide the following information from your financial records:

Fraction 1	Medicaid Revenues:			
	Plus: Government Cash Subsidies:			Fraction (1)
	Total patient revenues including cash subsidies:			
Fraction 2	Total hospital inpatient charges for charity care (not including allowances, discounts and bad debts):			
	Less: Government cash subsidies:			Fraction (2)
	Total inpatient charges:			
	Sum of Fraction (1) and (2) expressed as a percent:			

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
SFY 2011 INPATIENT
BILLING CODE ALLOCATION

New Line No.	Old Line No.	Cost Center Description	UB-92 Revenue Center Codes
30	25	Adults and Pediatrics	001, 100, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 230, 232, 239, 240-243, 249
31	26	Intensive Care Unit	200, 201-204, 208, 209, 233
32	27	Coronary Care Unit	210-213, 219, 234
33	28	Burn Intensive Care Unit	207
34	29	Surgical Intensive Care Unit	204
36	30	Other Special Care (specify)	*
40	25a	Subprovider - Distinct Psych Unit	114, 124, 134, 154
41	25b	Subprovider - Distinct Phys Rehab	118, 128, 138, 158
42	31	Nursery Intensive Care	174
43	33	Nursery	170-173, 179, 231
44	34	SNF | NF | ICF | OLTC	*
45		Other Routine (specify)	*
46		Other Routine (specify)	*
49	35	Sub-Total (Lines 30 - 48)	*
50	37	Operating Room	360-362, 367, 369
51	38	Recovery Room	710, 719
52	39	Labor Room and Delivery Room	720-724, 729
53	40	Anesthesiology	370-372, 379
54	41	Radiology-Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
55	42	Radiology-Therapeutic	330-333, 335, 339
56	43	Radioisotope	340-342, 349
57	41a	Computed Tomography (CT) Scan	350-352, 359
58	41d	Magnetic Resonance Imaging (MRI)	610-612, 614-616, 618, 619
59	53a	Cardiac Catheterization	481
60	44	Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
61	44A	Oncology	280, 289
62	46	Whole Blood & Packed Red Blood Cells	380-387, 389
63	47	Blood Storing, Processing, & Trans.	390, 391, 399
64	48	Intravenous Therapy	260-264, 269
65	49	Respiratory Therapy	410, 412, 413, 419
66	50	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
67	51	Occupational Therapy	430-434, 439
68	52	Speech Pathology / Audiology	440-444, 449, 470-472, 479
69	53	Electrocardiology	480, 482, 483, 489, 730-732, 739
70	54	Electroencephalography	740, 749
71	55	Medical Supplies Charged to Patients	270-272, 274-276, 278, 279, 291, 621-623
72		Implantable Devices Charged to Patients	*
73	56	Drugs Charged to Patients	250-252, 254, 255, 257-259, 634, 637
74	57	Renal Dialysis	800-804, 809, 880-881, 889
75	37a	ASC (Non-Distinct Part)	490, 499
76	59	Psychiatric / Psychologic	900, 909, 910, 914-916, 918-919
77	69	Gastrointestinal Svcs	750, 759
78	41b	Ultrasound	402
79	41c	PET Scan	404
80	49a	Pulmonary Function	460, 469
81	50a	Cardiac Rehabilitation	943
82	37c	Treatment / Observ Room / Cast Room	700, 709, 760-762, 769
88		Rural Health Clinic (RHC)	*
89		Federally Qualified Health Center (FQHC)	*
90	60	Clinic	510-517, 519, 770, 771, 779
91	61	Emergency	450-452, 456, 459
92	62	Observation Beds (see instructions)	*
93		Other Outpatient Service (specify)	*
100		Other Reimbursable (specify)	*
101		Outpatient Rehabilitation Provider (specify)	*
103		Ambulatory Surgical Center (Distinct Part)	*
105	58	Organ Acquisition	810-812, 819
106		Lines 106 - 132 Open for Provider Use	*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.
*Billing codes should be allocated into revenue centers as indicated above. Any deviation from the above must be designated above to indicate where the billing codes were allocated, and why they were allocated differently than requested.
*Do not include observation bed costs and charges reported on line 62 of the JFS 2930 and HCFA 2552-96 in revenue center 82.
*If one revenue center code is applicable to more than one revenue center, please show which revenue centers it was allocated to on the following page
* Please list the revenue center codes allocated to these revenue centers.

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
SFY 2011 INPATIENT
BILLING CODE ALLOCATION

Line	Line	Cost Center Description	UB-92 Revenue Center Codes
30	25	Adults and Pediatrics	001, 100, 110-113, 116, 117, 119-123, 126, 127, 129-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 230, 232, 239, 240-243, 249
31	26	Intensive Care Unit	200, 201-204, 208, 209, 233
32	27	Coronary Care Unit	210-213, 219, 234
33	28	Burn Intensive Care Unit	207
34	29	Surgical Intensive Care Unit	204
36	30	Other Special Care (specify)	*
40	25a	Subprovider - Distinct Psych Unit	114, 124, 134, 154
41	25b	Subprovider - Distinct Phys Rehab	118, 128, 138, 158
42	31	Nursery Intensive Care	174
43	33	Nursery	170-173, 179, 231
44	34	SNF | NF | ICF | OLTC	*
45		Other Routine (specify)	*
46		Other Routine (specify)	*
49	35	Sub-Total (Lines 30 - 48)	*
50	37	Operating Room	360-362, 367, 369
51	38	Recovery Room	710, 719
52	39	Labor Room and Delivery Room	720-724, 729
53	40	Anesthesiology	370-372, 379
54	41	Radiology-Diagnostic	320-324, 329, 400, 401, 403, 409, 790, 799, 920
55	42	Radiology-Therapeutic	330-333, 335, 339
56	43	Radioisotope	340-342, 349
57	41a	Computed Tomography (CT) Scan	350-352, 359
58	41d	Magnetic Resonance Imaging (MRI)	610-612, 614-616, 618, 619
59	53a	Cardiac Catheterization	481
60	44	Laboratory	300-302, 304-307, 309-312, 314, 319, 921, 923-925, 929
61	44A	Oncology	280, 289
62	46	Whole Blood & Packed Red Blood Cells	380-387, 389
63	47	Blood Storing, Processing, & Trans.	390, 391, 399
64	48	Intravenous Therapy	260-264, 269
65	49	Respiratory Therapy	410, 412, 413, 419
66	50	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949, 952
67	51	Occupational Therapy	430-434, 439
68	52	Speech Pathology / Audiology	440-444, 449, 470-472, 479
69	53	Electrocardiology	480, 482, 483, 489, 730-732, 739
70	54	Electroencephalography	740, 749
71	55	Medical Supplies Charged to Patients	270-272, 274-276, 278, 279, 291, 621-623
72		Implantable Devices Charged to Patients	*
73	56	Drugs Charged to Patients	250-252, 254, 255, 257-259, 634, 637
74	57	Renal Dialysis	800-804, 809, 880-881, 889
75	37a	ASC (Non-Distinct Part)	490, 499
76	59	Psychiatric / Psychologic	900, 909, 910, 914-916, 918-919
77	69	Gastrointestinal Svcs	750, 759
78	41b	Ultrasound	402
79	41c	PET Scan	404
80	49a	Pulmonary Function	460, 469
81	50a	Cardiac Rehabilitation	943
82	37c	Treatment / Observ Room / Cast Room	700, 709, 760-762, 769
88		Rural Health Clinic (RHC)	*
89		Federally Qualified Health Center (FQHC)	*
90	60	Clinic	510-517, 519, 770, 771, 779
91	61	Emergency	450-452, 456, 459
92	62	Observation Beds (see instructions)	*
93		Other Outpatient Service (specify)	*
94	63	Home Program Dialysis	*
95	64	Ambulance Services	*
96	65	Durable Medical Equipment-Rented	*
97	66	Durable Medical Equipment-Sold	*
98	67	Home Health Agency	*
99	68	Hospice	*
100		Other Reimbursable (specify)	*
101		Outpatient Rehabilitation Provider (specify)	*
102		Intern-Resident (not appvd. tchng. prgm.)	*
103		Ambulatory Surgical Center (Distinct Part)	*
105	58	Organ Acquisition	810-812, 819
106		Lines 106 - 132 Open for Provider Use	*

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

Follow the same procedures as outlined on the Inpatient Billing Code Allocation Sheet

Provider Name ______________________________

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

SETTLEMENT SUMMARY

SFY 2011 Settlement Summary

JFS 02930 Settlement Summary

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

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

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

Settlement Approved By

____
Auditor In Charge
Cost Reporting Unit

Date

____

Provider Name ______________________________

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

JFS 02930 Schedule A

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

NOTE: Please list professional fees by specific cost center.

Provider Name ________________________________

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

COST DISTRIBUTION

JFS 02930 Schedule B

	1 Facility Costs	2 Interns & Residents Costs	3 Total Facility Costs	4 Total Facility Charges	5 Ratio (3/4)	6 Total I/P Charges	7 Total I/P Costs	8 Total O/P Charges	9 Total O/P Costs	10 Total O/P Non-Reim Charges	11 Total O/P Non-Reim Costs
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
44. SNF	NF	ICF	OLTC											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											
50. Operating Room											
51. Recovery Room											
52. Labor Room and Delivery Room											
53. Anesthesiology											
54. Radiology-Diagnostic											
55. Radiology-Therapeutic											
56. Radioisotope											
57. Computed Tomography (CT) Scan											
58. Magnetic Resonance Imaging (MRI)											
59. Cardiac Catheterization											
60. Laboratory											
61. Oncology											
62. Whole Blood & Packed Red Blood Cells											
63. Blood Storing, Processing, & Trans.											
64. Intravenous Therapy											
65. Respiratory Therapy											
66. Physical Therapy											
67. Occupational Therapy											
68. Speech Pathology / Audiology											
69. Electrocardiology											
70. Electroencephalography											
71. Medical Supplies Charged to Patients											
72. Implantable Devices Charged to Patients											
73. Drugs Charged to Patients											
74. Renal Dialysis											
75. ASC (Non-Distinct Part)											
76. Psychiatric / Psychologic											
77. Gastrointestinal Svcs											
78. Ultrasound											
79. PET Scan											
80. Pulmonary Function											
81. Cardiac Rehabilitation											
82. Treatment / Observ Room / Cast Room											
88. Rural Health Clinic (RHC)											
89. Federally Qualified Health Center (FQHC)											
90. Clinic											

Provider Name ______________________________

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

COST DISTRIBUTION

JFS 02930 Schedule B

	1 Facility Costs	2 Interns & Residents Costs	3 Total Facility Costs	4 Total Facility Charges	5 Ratio (3/4)	6 Total I/P Charges	7 Total I/P Costs	8 Total O/P Charges	9 Total O/P Costs	10 Total O/P Non-Reim Charges	11 Total O/P Non-Reim Costs
91. Emergency											
92. Observation Beds (see instructions)											
93. Other Outpatient Service (specify)											
94. Home Program Dialysis											
95. Ambulance Services											
96. Durable Medical Equipment-Rented											
97. Durable Medical Equipment-Sold											
98. Home Health Agency											
99. Hospice											
100. Other Reimbursable (specify)											
101. Outpatient Rehabilitation Provider (specif											
102. Intern-Resident (not appvd. tchng. prgm											
103. Ambulatory Surgical Center (Distinct Part											
105. Organ Acquisition											
106.											
107.											
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127.											
128.											
129.											
130.											
131.											
132.											
199. Subtotal (sum of lines 50 to 198)											
200. Subtotal (sum of lines 49 + 199)											
201. Less Observation Beds											
202. Total (line 200 minus line 201)											

Provider Name ______________________________

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

TITLE XIX ROOM COST COMPUTATION

JFS 02930 Schedule C

SECTION I	1 Total Costs All Patients	2 Swing Bed Costs	3 Adj Total Costs Col 1 + 2	4 Total Facility Days	5 Per Diem Col 3 / 4	6 Title XIX Days	7 Title XIX Costs Col 5 * 6	8 Title V Days	9 Title V Costs Col 5 * 8	10 Title XIX Trans Days	11 Title XIX Trans Costs Col 5 * 10
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											

DISCHARGE STATISTICS

JFS 02930 Schedule C-1

SECTION I - INPATIENT DATA	Total Facility	Title XIX On or Before 12/31/10	Title XIX On or After 01/01/11	Title V	Title XIX Transplant	Medicaid HMO On or Before 12/31/10	Medicaid HMO On or After 01/01/11
50. Adult & Ped							
51. Distinct Part Psych							
52. Distinct Part Rehab							
53. Nursery							
54. Total							
55. Capital Add-On Rate							

SECTION II - OUTPATIENT DATA

56. Outpatient Visits

SECTION III - MISC. DATA

57. Total Hospital Beds

58. Net Number of Interns & Residents

MEDICAID HMO INPATIENT DAYS

JFS 02930 Schedule C-2

SECTION I	Per Diem (Sec. I, Col 5)	Medicaid HMO Days	Medicaid HMO Costs
30. Adults and Pediatrics			
31. Intensive Care Unit			
32. Coronary Care Unit			
33. Burn Intensive Care Unit			
34. Surgical Intensive Care Unit			
36. Other Special Care (specify)			
40. Subprovider - Distinct Psych Unit			
41. Subprovider - Distinct Phys Rehab			
42. Nursery Intensive Care			
43. Nursery			
45. Other Routine (specify)			
46. Other Routine (specify)			
49. Sub-Total (Lines 30 - 48)			

Provider Name ______________________________

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

TITLE XIX COST COMPUTATION

JFS 02930 Schedule D

	1 Ratio	2 Title XIX I/P Charges	3 Title XIX I/P Costs	4 Title XIX O/P Charges	5 Title XIX O/P Costs	6 Title XIX O/P Lab Charges	7 Title XIX O/P Lab Costs	8 Title XIX Transplant Charges	9 Title XIX Transplant Costs
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									
89. Federally Qualified Health Center (FQHC)									

Provider Name ______________________________

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

TITLE XIX COST COMPUTATION

JFS 02930 Schedule D

	1	2	3	4	5	6	7	8	9
	Ratio	Title XIX I/P Charges	Title XIX I/P Costs	Title XIX O/P Charges	Title XIX O/P Costs	Title XIX O/P Lab Charges	Title XIX O/P Lab Costs	Title XIX Transplant Charges	Title XIX Transplant Costs
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
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131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									

Provider Name ______________________________

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

TITLE V COST COMPUTATION

JFS 02930 Schedule D1

	1 Total Costs	2 Prof. Component	3 Adjusted Costs	4 Total Charges	5 Prof. Component	6 Adjusted Charges	7 Ratio	8 Title V I/P Charges	9 Title V I/P Costs	10 Title V op Charges	11 Title V O/P Costs
30. Adults and Pediatrics											
31. Intensive Care Unit											
32. Coronary Care Unit											
33. Burn Intensive Care Unit											
34. Surgical Intensive Care Unit											
36. Other Special Care (specify)											
40. Subprovider - Distinct Psych Unit											
41. Subprovider - Distinct Phys Rehab											
42. Nursery Intensive Care											
43. Nursery											
45. Other Routine (specify)											
46. Other Routine (specify)											
49. Sub-Total (Lines 30 - 48)											
50. Operating Room											
51. Recovery Room											
52. Labor Room and Delivery Room											
53. Anesthesiology											
54. Radiology-Diagnostic											
55. Radiology-Therapeutic											
56. Radioisotope											
57. Computed Tomography (CT) Scan											
58. Magnetic Resonance Imaging (MRI)											
59. Cardiac Catheterization											
60. Laboratory											
61. Oncology											
62. Whole Blood & Packed Red Blood Cells											
63. Blood Storing, Processing, & Trans.											
64. Intravenous Therapy											
65. Respiratory Therapy											
66. Physical Therapy											
67. Occupational Therapy											
68. Speech Pathology / Audiology											
69. Electrocardiology											
70. Electroencephalography											
71. Medical Supplies Charged to Patients											
72. Implantable Devices Charged to Patients											
73. Drugs Charged to Patients											
74. Renal Dialysis											
75. ASC (Non-Distinct Part)											
76. Psychiatric / Psychologic											
77. Gastrointestinal Svcs											
78. Ultrasound											
79. PET Scan											
80. Pulmonary Function											
81. Cardiac Rehabilitation											
82. Treatment / Observ Room / Cast Room											
88. Rural Health Clinic (RHC)											
89. Federally Qualified Health Center (FQHC)											
90. Clinic											
91. Emergency											

Provider Name ______________________________

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

TITLE V COST COMPUTATION

JFS 02930 Schedule D1

	1	2	3	4	5	6	7	8	9	10	11
	Total Costs	Prof. Component	Adjusted Costs	Total Charges	Prof. Component	Adjusted Charges	Ratio	Title V I/P Charges	Title V I/P Costs	Title V op Charges	Title V O/P Costs
92. Observation Beds (see instructions)											
93. Other Outpatient Service (specify)											
100. Other Reimbursable (specify)											
101. Outpatient Rehabilitation Provider (specify)											
102. Intern-Resident (not appvd. tchng. prgm.)											
103. Ambulatory Surgical Center (Distinct Part)											
105. Organ Acquisition											
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130.											
131.											
132.											
199. Subtotal (sum of lines 50 to 198)											
202. Total (sum of lines 49 + 199)											

Provider Name ________________________________

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

Miscellaneous Cost & Payment Information

JFS 02930 Schedule E/F

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

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

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

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

UNCOMPENSATED CARE DATA

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

	Total Discharges / Visits Patients		Unduplicated Discharges / Visits Patients	
Inpatient Discharges	w/ Insurance	w/ No Insurance	w/ Insurance	w/ No Insurance
16. Disability Assistance				
17. Uncompensated Care < 100%				
18. Uncompensated Care > 100%				
19. Total Inpatient				
Outpatient Visits				
20. Disability Assistance				
21. Uncompensated Care < 100%				
22. Uncompensated Care > 100%				
23. Total Outpatient				

Section II

Free Standing Psych Hospitals	Payments From Insurance	Payments From Self-Pay	Charges From Charity Care	Gov't Cash Subsidies Rec.	Uncomp Costs Patients With Insurance	Medicaid Days Age 21 and Under	Medicaid Days Age 22 to 64	Medicaid Days Age 65 and Over
24. Required Data								

Provider Name ______________________________

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

Disability Assistance (DA) - Detail

JFS 02930 Schedule F1

	1 Ratio	2 I/P Charges DA w/ Ins.	3 I/P Costs DA w/ Ins.	4 O/P Charges DA w/ Ins.	5 O/P Costs DA w/ Ins.	6 I/P Charges DA w/o Ins.	7 I/P Costs DA w/o Ins.	8 O/P Charges DA w/o Ins.	9 O/P Costs DA w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name ______________________________

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

Disability Assistance (DA) - Detail

JFS 02930 Schedule F1

	1 Ratio	2 I/P Charges DA w/ Ins.	3 I/P Costs DA w/ Ins.	4 O/P Charges DA w/ Ins.	5 O/P Costs DA w/ Ins.	6 I/P Charges DA w/o Ins.	7 I/P Costs DA w/o Ins.	8 O/P Charges DA w/o Ins.	9 O/P Costs DA w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
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130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts | Net Costs									
205. Total Discharges | Visits									
206. Unduplicated Discharges | Visits									

Provider Name ______________________________

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

Uncompensated Care (UC) < 100% - Detail

JFS 02930 Schedule F2

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name ______________________________

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

Uncompensated Care (UC) < 100% - Detail

JFS 02930 Schedule F2

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
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128.									
129.									
130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts / Net Costs									
205. Total Discharges / Visits									
206. Unduplicated Discharges / Visits									

Provider Name ________________________________

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

Uncompensated Care (UC) > 100% - Detail

JFS 02930 Schedule F3

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
30. Adults and Pediatrics									
31. Intensive Care Unit									
32. Coronary Care Unit									
33. Burn Intensive Care Unit									
34. Surgical Intensive Care Unit									
36. Other Special Care (specify)									
40. Subprovider - Distinct Psych Unit									
41. Subprovider - Distinct Phys Rehab									
42. Nursery Intensive Care									
43. Nursery									
45. Other Routine (specify)									
46. Other Routine (specify)									
49. Sub-Total (Lines 30 - 48)									
50. Operating Room									
51. Recovery Room									
52. Labor Room and Delivery Room									
53. Anesthesiology									
54. Radiology-Diagnostic									
55. Radiology-Therapeutic									
56. Radioisotope									
57. Computed Tomography (CT) Scan									
58. Magnetic Resonance Imaging (MRI)									
59. Cardiac Catheterization									
60. Laboratory									
61. Oncology									
62. Whole Blood & Packed Red Blood Cells									
63. Blood Storing, Processing, & Trans.									
64. Intravenous Therapy									
65. Respiratory Therapy									
66. Physical Therapy									
67. Occupational Therapy									
68. Speech Pathology / Audiology									
69. Electrocardiology									
70. Electroencephalography									
71. Medical Supplies Charged to Patients									
72. Implantable Devices Charged to Patients									
73. Drugs Charged to Patients									
74. Renal Dialysis									
75. ASC (Non-Distinct Part)									
76. Psychiatric / Psychologic									
77. Gastrointestinal Svcs									
78. Ultrasound									
79. PET Scan									
80. Pulmonary Function									
81. Cardiac Rehabilitation									
82. Treatment / Observ Room / Cast Room									
88. Rural Health Clinic (RHC)									

Provider Name ______________________________

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

Uncompensated Care (UC) > 100% - Detail

JFS 02930 Schedule F3

	1 Ratio	2 I/P Charges UC w/ Ins.	3 I/P Costs UC w/ Ins.	4 O/P Charges UC w/ Ins.	5 O/P Costs UC w/ Ins.	6 I/P Charges UC w/o Ins.	7 I/P Costs UC w/o Ins.	8 O/P Charges UC w/o Ins.	9 O/P Costs UC w/o Ins.
89. Federally Qualified Health Center (FQHC)									
90. Clinic									
91. Emergency									
92. Observation Beds (see instructions)									
93. Other Outpatient Service (specify)									
100. Other Reimbursable (specify)									
101. Outpatient Rehabilitation Provider (specify)									
102. Intern-Resident (not appvd. tchng. prgm.)									
103. Ambulatory Surgical Center (Distinct Part)									
105. Organ Acquisition									
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130.									
131.									
132.									
199. Subtotal (sum of lines 50 to 198)									
202. Total (sum of lines 49 + 199)									
204. Receipts | Net Costs									
205. Total Discharges | Visits									
206. Unduplicated Discharges | Visits									

Provider Name ________________________________

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

CAPITAL RELATED COST REIMBURSEMENT

JFS 02930 Schedule G

	1 Total Charges All Patients	2 Capital Cost	3 Reserved	4 Total Capital Cost	5 Ratio	6 Title XIX I/P Charges	7 Title XIX Capital Cost
30. Adults and Pediatrics							
31. Intensive Care Unit							
32. Coronary Care Unit							
33. Burn Intensive Care Unit							
34. Surgical Intensive Care Unit							
36. Other Special Care (specify)							
40. Subprovider - Distinct Psych Unit							
41. Subprovider - Distinct Phys Rehab							
42. Nursery Intensive Care							
43. Nursery							
44. SNF | NF | ICF | OLTC							
45. Other Routine (specify)							
46. Other Routine (specify)							
49. Sub-Total (Lines 30 - 48)							
50. Operating Room							
51. Recovery Room							
52. Labor Room and Delivery Room							
53. Anesthesiology							
54. Radiology-Diagnostic							
55. Radiology-Therapeutic							
56. Radioisotope							
57. Computed Tomography (CT) Scan							
58. Magnetic Resonance Imaging (MRI)							
59. Cardiac Catheterization							
60. Laboratory							
61. Oncology							
62. Whole Blood & Packed Red Blood Cells							
63. Blood Storing, Processing, & Trans.							
64. Intravenous Therapy							
65. Respiratory Therapy							
66. Physical Therapy							
67. Occupational Therapy							
68. Speech Pathology / Audiology							
69. Electrocardiology							
70. Electroencephalography							
71. Medical Supplies Charged to Patients							
72. Implantable Devices Charged to Patients							
73. Drugs Charged to Patients							
74. Renal Dialysis							
75. ASC (Non-Distinct Part)							
76. Psychiatric / Psychologic							
77. Gastrointestinal Svcs							
78. Ultrasound							
79. PET Scan							
80. Pulmonary Function							
81. Cardiac Rehabilitation							
82. Treatment / Observ Room / Cast Room							
88. Rural Health Clinic (RHC)							
89. Federally Qualified Health Center (FQHC)							
90. Clinic							

Provider Name ______________________________

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

CAPITAL RELATED COST REIMBURSEMENT

JFS 02930 Schedule G

	1 Total Charges All Patients	2 Capital Cost	3 Reserved	4 Total Capital Cost	5 Ratio	6 Title XIX I/P Charges	7 Title XIX Capital Cost
91. Emergency							
92. Observation Beds (see instructions)							
93. Other Outpatient Service (specify)							
94. Home Program Dialysis							
95. Ambulance Services							
96. Durable Medical Equipment-Rented							
97. Durable Medical Equipment-Sold							
98. Home Health Agency							
99. Hospice							
100. Other Reimbursable (specify)							
101. Outpatient Rehabilitation Provider (specify)							
102. Intern-Resident (not appvd. tchng. prgm.)							
103. Ambulatory Surgical Center (Distinct Part)							
105. Organ Acquisition							
106.							
107.							
108.							
109.							
110.							
111.							
112.							
113.							
114.							
115.							
116.							
117.							
118.							
119.							
120.							
121.							
122.							
123.							
124.							
125.							
126.							
127.							
128.							
129.							
130.							
131.							
132.							
199. Subtotal (sum of lines 50 to 198)							
200. Total							
201. Capital Payments For Period							
202. Amount Due Program/(Provider)							

Provider Name ______________________________

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

SETTLEMENT CALCULATION

JFS 02930 Schedule H

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

Provider Name ________________________________

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

Title XIX HMO Cost Computation

JFS 02930 Schedule I

	1 Ratio	2 Title XIX HMO I/P Charges	3 Title XIX HMO I/P Costs	4 Title XIX HMO O/P Charges	5 Title XIX HMO O/P Costs	6	7 Capital Ratio	8 Title XIX HMO Capital Costs
30. Adults and Pediatrics								
31. Intensive Care Unit								
32. Coronary Care Unit								
33. Burn Intensive Care Unit								
34. Surgical Intensive Care Unit								
36. Other Special Care (specify)								
40. Subprovider - Distinct Psych Unit								
41. Subprovider - Distinct Phys Rehab								
42. Nursery Intensive Care								
43. Nursery								
45. Other Routine (specify)								
46. Other Routine (specify)								
49. Sub-Total (Lines 30 - 48)								
50. Operating Room								
51. Recovery Room								
52. Labor Room and Delivery Room								
53. Anesthesiology								
54. Radiology-Diagnostic								
55. Radiology-Therapeutic								
56. Radioisotope								
57. Computed Tomography (CT) Scan								
58. Magnetic Resonance Imaging (MRI)								
59. Cardiac Catheterization								
60. Laboratory								
61. Oncology								
62. Whole Blood & Packed Red Blood Cells								
63. Blood Storing, Processing, & Trans.								
64. Intravenous Therapy								
65. Respiratory Therapy								
66. Physical Therapy								
67. Occupational Therapy								
68. Speech Pathology / Audiology								
69. Electrocardiology								
70. Electroencephalography								
71. Medical Supplies Charged to Patients								
72. Implantable Devices Charged to Patients								
73. Drugs Charged to Patients								
74. Renal Dialysis								
75. ASC (Non-Distinct Part)								
76. Psychiatric / Psychologic								
77. Gastrointestinal Svcs								
78. Ultrasound								
79. PET Scan								
80. Pulmonary Function								
81. Cardiac Rehabilitation								
82. Treatment / Observ Room / Cast Room								
88. Rural Health Clinic (RHC)								
89. Federally Qualified Health Center (FQHC)								
90. Clinic								
91. Emergency								

Provider Name ______________________________

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

Title XIX HMO Cost Computation

JFS 02930 Schedule I

	1 Ratio	2 Title XIX HMO I/P Charges	3 Title XIX HMO I/P Costs	4 Title XIX HMO O/P Charges	5 Title XIX HMO O/P Costs	6	7 Capital Ratio	8 Title XIX HMO Capital Costs
92. Observation Beds (see instructions)								
93. Other Outpatient Service (specify)								
100. Other Reimbursable (specify)								
101. Outpatient Rehabilitation Provider (specify)								
102. Intern-Resident (not appvd. tchng. prgm.)								
103. Ambulatory Surgical Center (Distinct Part)								
105. Organ Acquisition								
106.								
107.								
108.								
109.								
110.								
111.								
112.								
113.								
114.								
115.								
116.								
117.								
118.								
119.								
120.								
121.								
122.								
123.								
124.								
125.								
126.								
127.								
128.								
129.								
130.								
131.								
132.								
199. Subtotal (sum of lines 50 to 198)								
202. Total (sum of lines 49 + 199)								
203. Estimate of Capital Payments								
204. Title XIX HMO Days/Visits								
205. Total Facility HMO Days/Visits								
206. Title XIX HMO Discharges								
207. Total Facility HMO Discharges								
208. Title XIX HMO Payments								