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Ohio Revised Code

Section 5168.20 [Repealed Effective 10/1/2023] Definitions for sections 5168.20 to 5168.28.

Effective: September 29, 2013
Legislation: House Bill 59 - 130th General Assembly

As used in sections 5168.20 to 5168.28 of the Revised Code:

(A) "Applicable assessment percentage" means the percentage specified in rules adopted under section 5168.26 of the Revised Code that is used in calculating a hospital's assessment under section 5168.21 of the Revised Code.

(B) "Assessment program year" means the twelve-month period beginning the first day of October of a calendar year and ending the last day of September of the following calendar year.

(C) "Cost reporting period" means the period of time used by a hospital in reporting costs for purposes of the medicare program.

(D) "Federal fiscal year" means the twelve-month period beginning the first day of October of a calendar year and ending the last day of September of the following calendar year.

(E)(1) Except as provided in division (E)(2) of this section, "hospital" means a hospital to which any of the following applies:

(a) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital and provides inpatient hospital services, as defined in 42 C.F.R. 440.10.

(b) The hospital is recognized under the medicare program as a cancer hospital and is exempt from the medicare prospective payment system.

(c) The hospital is a psychiatric hospital licensed under section 5119.33 of the Revised Code.

(2) "Hospital" does not include either of the following:

(a) A federal hospital;

(b) A hospital that does not charge any of its patients for its services.

(F) "Hospital care assurance program" means the program established under sections 5168.01 to 5168.14 of the Revised Code.

(G) "State fiscal year" means the twelve-month period beginning the first day of July of a calendar year and ending the last day of June of the following calendar year.

(H)(1) Except as provided in divisions (H)(2) and (3) of this section, "total facility costs" means the total costs to a hospital for all care provided to all patients, including the direct, indirect, and overhead costs to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation.

(2) "Total facility costs" excludes all of the following of a hospital's costs as shown on the cost-reporting data used for purposes of determining the hospital's assessment under section 5168.21 of the Revised Code:

(a) Skilled nursing services provided in distinct-part nursing facility units;

(b) Home health services;

(c) Hospice services;

(d) Ambulance services;

(e) Renting durable medical equipment;

(f) Selling durable medical equipment.

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(3) "Total facility costs" excludes any costs excluded from a hospital's total facility costs pursuant to rules, if any, adopted under division (B)(1) of section 5168.26 of the Revised Code.