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State/Territory Name: OH

State Plan Amendment (SPA) #: 16-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

MAY 31 2016

John McCarthy, Medicaid Director
Office of Ohio Health Plans
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

RE: Ohio State Plan Amendment (SPA) 16-006

Dear Mr. McCarthy:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-006. Effective February 3, 2016, this SPA requests approval from the Centers for Medicare and Medicaid Services (CMS) to update provisions in Attachment 3.1-A and Attachment 4.19-D, Supplement 1, and to delete obsolete provisions in both attachments.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 16-006 is approved effective February 3, 2016. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please contact Fred Sebree at (217) 492-4122 or Fredrick.sebree@cms.hhs.gov.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosure

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **16-006 (Revised)**	2. STATE **OHIO**
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE **February 3, 2016**	

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ **AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:	7. FEDERAL BUDGET IMPACT:
Section 1902(a)(13)(A) of the Social Security Act Section 1902(a)(30)(A) of the Social Security Act 42 C.F.R. 447.205	a. FFY 2016 $0 thousands b. FFY 2017 $0 thousands
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1-A Item 4-a, page 1 of 1	**Attachment 3.1-A** Pre-Print Page 2 Item 4-a, page 1 of 2 (TN 93-39) Pre-Print Page 2 Item 4-a, page 2 of 2 (TN 94-31) Remove Supp. 2, Section 5101:3-3-05, pages 1-3 of 3 (TN 93-30) Remove Supp. 2, Section 5101:3-3-06, pages 1-3 of 3 (TN 93-30) Remove Supp. 2, Section 5101:3-3-07, pages 1-3 of 3 (TN 97-16) Remove Supp. 2, Section 5101:3-3-15, pages 1-20 of 20 (TN 93-40) Remove (except page 19a)
Attachment 4.19-B Item 4	**Attachment 4.19-B** Item 4 (TN 93-39)
Attachment 4.19-D, Supplement 1: Section 5165.10.003 Appendix A, pages 1-61 of 61	**Attachment 4.19-D, Supplement 1:** Section 5111.26.003 Appendix A, pages 1-61 of 61 (TN 13-022) Section 5111.27.001, pages 1-2 of 2 (TN 06-010) Remove

10. SUBJECT OF AMENDMENT: Payment for services: Nursing Facility services – Cost Report changes

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The State Medicaid Director is the Governor's designee

12. SIGNATURE OF STATE AGENCY OFFICIAL: [redacted]	16. RETURN TO:
13. TYPED NAME: **JOHN B. McCARTHY**	**Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: March 3, 2016	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: MAY 31 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: FEB 03 2016	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMCo

23. REMARKS:

4-a. Nursing facility services (other than services in an institution of mental diseases) for individuals 21 years of age or older.

Included in the nursing facility per diem rate is room and board, including a private room if medically necessary. The services included and not included in the nursing facility per diem rate are specified in Section 001.4 of Attachment 4.19-D, Supplement 1.

4a. Skilled Nursing Facility Services for Individuals Under 21 Years of Age or Older

PLACE HOLDER

4b. Early and Periodic Screening Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found

Payment is made according to the provider type rendering service as described elsewhere in this schedule. Environmental assessments performed by the Ohio Department of Health will be reimbursed at a cost based negotiated rate.

4c. Family Planning

Payment is made according to the provider type rendering service as described elsewhere in this schedule.

Instructions for completing the Ohio Department of Medicaid annual Medicaid cost report for nursing facilities (NFs)

GENERAL INSTRUCTIONS

OVERVIEW

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

If a provider begins operations on or after October 2, the cost report shall be filed in accordance with rule 5160-3-20 of the Ohio Administrative Code (OAC).

For cost reporting purposes, NFs, other than state-operated facilities, shall use the Chart of Accounts as set forth in rule 5160-3-42 of the OAC, or relate its chart of accounts directly to the cost report.

TN 16-006 Approved MAY 31 2016
Supersedes
TN 13-022 Effective 02/03/2016

ELECTRONIC SUBMISSION OF THE MEDICAID COST REPORT

In accordance with the OAC, all providers are required to use the electronic cost report submission process. Providers should use the Department-sponsored computer software for electronic submission of the cost report.

FILING REQUIREMENTS

A complete and adequate Medicaid cost report must be filed with the Department or postmarked on or before ninety days after the end of each facility's reporting period. Pursuant to Ohio Revised Code (ORC) section 5165.10, a provider whose cost report is filed or postmarked after this date, is subject to a reduction of their per diem rate in the amount of two dollars ($2.00) per resident day, adjusted for inflation. The late file period will begin at the start of the thirty day termination period and continue until the complete and adequate cost report is received by the Department or the facility is terminated from the Medicaid program.

A provider may request a fourteen-day extension of the cost report filing deadline. Such requests must be made in writing, including an explanation of the reason the extension is being requested, and must demonstrate good cause in order to be granted. Requests should be made to the Rate Setting and Cost Settling Unit, Department of Medicaid.

In the absence of a timely filed complete and adequate cost report, or request for filing extension, a provider will be notified by the Department of its failure to file a complete and adequate cost report and will be given thirty days to file the appropriate cost report and attachments. During this thirty day period, the late filing rate reduction described previously will be assessed. If a provider fails to submit a complete and adequate cost report within this time period, its Medicaid provider agreement will be terminated according to section 5165.106 of the ORC.

REASONABLE COST

Please read all instructions carefully before completing the cost report.

Reasonable cost takes into account direct, ancillary/support, capital and tax costs of providers of services, including normal standby costs. Departmental regulations regarding the reasonable and allowable costs are contained in Chapter 5160-3 of the OAC. In addition, the following additional provisions establish guidelines and procedures to be used in determining reasonable costs for services rendered by NFs:

- Ohio Revised Code and uncodified state law,
- Regulations (OAC) promulgated by the Department and codified in accordance with state law,
- Principles of reimbursement for provider costs with related policies described in the Centers for Medicare and Medicaid Services (CMS) Publication 15-1,
- Principles of reimbursement for provider costs with related policies described in the Code of Federal Regulations (CFR), Title 42, Part 413.

ROUTINE SERVICES

The OAC lists covered services for all providers who serve NF residents. The OAC delineates services reimbursed through the cost reporting mechanism of NFs, and the costs directly billed to Medicaid by service providers other than NFs.

ACCOUNTING BASIS

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

OHIO MEDICAID COST REPORT FORMS

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

COST REPORT SCHEDULES

The provider must complete the information requested on each cost report schedule. Except for the cost report schedules and attachments listed below, responses such as "Not Applicable," "N/A," "Same as Above," "Available upon request," or "Available at the time of Audit," will result in the cost report being deemed incomplete or inadequate. Pursuant to sections 5165.10 and 5165.106 of the ORC, an incomplete or an inadequate cost report is subject to a rate reduction of $2.00 per resident per day, adjusted for inflation, as well as proposed termination of the provider agreement.

TABLE OF COST REPORT SCHEDULES

COST REPORT INSTRUCTIONS

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

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

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

Sequence and Procedures for Completing Cost Report		Cost Report Page Number
1.	Schedule A, Page 1 of 2, Identification	1
2.	Schedule A-1	3
3.	Schedule A, Page 1 of 2, statistical data line 1 through line 8	1
4.	Attachment 1	23–25
5.	Schedule A-2	4
6.	Schedule B-1 (columns 1 through 3)	6
7.	Schedule B-2 (columns 1 through 3)	7–8
8.	Schedule C (columns 1 through 3)	9–11
9.	Schedule D-1	19
10.	Schedule D-2	20
11.	Schedule D (column 3)	18
12.	Attachment 2	26
13.	Schedules B-1, B-2, C and D (columns 4–7)	6–11, 18
14.	Schedule C-1	12
15.	Schedule C-2	13–14
16.	Schedule C-3	15–17
17.	Schedule E	21
18.	Schedule E-1	22
19.	Schedule A-3	5
20.	Attachment 6	28–29
21.	Attachment 7	30
22.	Attachment 8	31
23.	Attachment 3	27
24.	Schedule A, Page 2 of 2	2

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

INTRODUCTION:

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

4.1 – Year End	Cost reports by providers with continued Medicaid participation having ending dates of December 31, pursuant to Ohio Administrative Code.
4.2 – New Facility	For facilities new to the Medicaid program, where the actual cost of operations are reported for the first three (3) full calendar months, which includes the date of certification, pursuant to OAC.
4.5 – Final	For the final cost report of a provider who has experienced a change of operator pursuant to OAC.
4.6 – Amended	For cost reports that are filed after the fiscal year rate setting and correct errors of the cost report used to establish the fiscal year rate, pursuant to OAC.

Facility Identification

Provider Name (DBA) – Enter the "doing business as" (DBA) name of the facility as it is registered with the Ohio Secretary of State.

National Provider Identifier (NPI) – Enter the NPI.

Medicaid Provider Number – Enter the seven digit Medicaid provider number as it appears on the Medicaid provider agreement.

CMS Certification Number (CCN), formerly the Medicare Provider Number – Enter the six-digit CCN furnished by the Ohio Department of Health (ODH) or CMS. CCNs are assigned to each facility regardless of the facility's Medicare certification status. The CCN also appears on the Medicaid provider agreement.

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

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

ODH ID Number – Enter the Ohio Department of Health (ODH) 4-digit home number, also referred to by ODH as the "Fac ID" Number.

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

Period Covered by the Cost Report

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

Provider Legal Entity Identification

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

Type of Control of Provider

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

For Profit

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

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

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

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

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

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

Publicly Traded Company – A company issuing stocks that are traded on the open market, either on a stock exchange or on the over-the-counter market. Individual and institutional shareholders constitute

the owners of a publicly traded company in proportion to the amount of stock they own as a percentage of all outstanding stock.

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

limited partnership, trust, estate, association, limited liability company, custodian, nominee, trustee, executor, administrator, or other fiduciary.

Business Trust – A business trust is created by a trust agreement and can only be created for specific purposes: To hold, manage, administer, control, invest, reinvest, and operate property; to operate business activities; to operate professional activities; to engage in any lawful act or activity for which business trusts may be formed under Chapter 1746. of the ORC.

Location of Entity, Organization or Incorporation

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

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

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

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

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

Nonprofit

Nonprofit Corporation – A domestic or foreign corporation organized otherwise than for pecuniary gain or profit. A nonprofit corporation can be either a "mutual benefit corporation" or a "public benefit corporation." A "public benefit corporation" is a corporation that is recognized as exempt from federal income taxation under 26 U.S.C. 1, Sec. 501(c)(3), or is organized for a public or charitable purpose and that, upon dissolution, must distribute its assets to a public benefit corporation, the United States, a state or any political subdivision of a state, or a person recognized as exempt from federal income taxation under 26 U.S.C. 1, Sec. 501(c)(3).

Nonprofit Limited Liability Company – (See description of for profit **Limited Liability Company**) Nonprofit limited liability companies may be formed in Ohio, and foreign nonprofit limited liability companies may be registered in Ohio. Section 1705.02 of the Ohio Revised Code states that "A limited liability company may be formed for any purpose or purposes for which individuals lawfully may associate themselves, including for any profit or nonprofit purpose...." Section 5701.14 states that, "In order to determine a limited liability company's nonprofit status, an entity is operating with a nonprofit purpose under section 1705.02 of the Revised Code if that entity is organized other than for the pecuniary gain or profit of, and its net earnings or any part of its net earnings are not distributable to, its members, its directors, its officers, or other private persons, except that the payment of reasonable compensation for services rendered, payments and distributions in furtherance of its nonprofit purpose, and the distribution of assets on dissolution permitted by section 1702.49 of the Revised Code are not pecuniary gain or profit or distribution of net earnings."

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

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

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

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

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

Nonfederal Government

State – Entity operated under the authority of the state.

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

City – Entity operated under the authority of the city.

City/County – Entity operated under the authority of the city and county.

Practice Type

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

Definitions

Physical Rehab Hospital Based – A hospital engaged primarily in providing specialized care to inpatients with intensive, multi-disciplinary physical restorative service needs.

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

Long Term Acute Care Hospital (LTACH) Based – A hospital that is classified as a long-term care hospital under 42 C.F.R. 412.23(e), that is engaged primarily in providing medically necessary specialized acute hospital care for medically complex patients who are critically ill or have multi-system complications or failures, and that has an average length of stay of forty-five days or less.

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

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

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

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

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

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

2. Schedule A-1, Summary of Inpatient Days

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

For example:

March 1, 20CY 100 certified beds

March 16, 20CY 120 certified beds

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

Average medicaid certified beds for March 20CY = 110

Column 2: Record the number of authorized skilled, intermediate, and Medicaid inpatient days.

The day of admission, but not the day of discharge, is an inpatient day. When a resident is admitted and discharged on the same day, this is counted as one inpatient day.

Inpatient days include those leave days that are reimbursable under the Ohio Medicaid program. Private leave days are not included as inpatient days. Carry the total on line 13, column 9 forward to Schedule A, line 4, column 1.

Column 3: Record the number of Medicaid days for those residents covered by the MyCare Ohio program. Leave days should be included.

Column 4 and 5: Record the total monthly reimbursable leave days for Medicaid residents [see the OAC - coverage of medically necessary days and limited absences].

NFs report each medically necessary day and limited absence as 50% of an inpatient day. Report days at 50% of inpatient days in columns 4 and 5.

For Example:

January 20CY 100 certified beds

January 20CY 3100 bed days available
(100 certified beds x 31 days in January)

Actual number of days residents are in facility = 3000
Actual number of days residents out of facility on medical leave = 60
Actual number of days residents are out of facility on therapeutic leave = 40

Report as follows if paid at 50% of an inpatient day:

Column 4	Hospital Leave Days	30	(60 days x 50%)
Column 5	Therapeutic Leave Days	20	(40 days x 50%)

Note that the calculation of inpatient days should round to two decimal places.

Column 6: Total of columns 2, 3, 4 and 5. Carry the total on line 13, column 6 forward to Schedule A, line 7.

Column 7: Record the number of Medicaid managed care days.

Column
8, 9 and 11: Record the number of inpatient days for non-Medicaid eligible residents. Leave days should be included in column 8 (Private Days), but not in columns 9 and 11.

Column 10: Record the number of Medicare days for those residents covered by the MyCare Ohio program.

Column 12: Record the number of inpatient days for all residents. This column is the sum of columns 6 through 11.

3. Schedule A, Page 1 of 2, Statistical Data

Lines 1 and 2: Licensed Beds:

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

Line 3: Total Bed Days:

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

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

Line 4: Total Inpatient Days:

For column 1, obtain the answer from Schedule A-1, column 10, line 13. For column 2, enter the total number of inpatient days for the facility for all ODH licensed beds.

Line 5: Percentage of Occupancy:

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

Line 6: Ancillary/Support Allowable Days:

For computing Ancillary/Support costs, the Department will not recognize an occupancy rate of less than 90%. If percentage of occupancy is 90% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 90%, enter 90% of the number of bed days stated on line 3 (See the OAC). For providers on the Medicaid program less than 12 months, also consult the OAC.

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

4. Attachment 1 – Revenue Trial Balance

Column 2: Enter total revenue for each line item.

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

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

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

Section A: Revenues

Lines 1a, 2a, and 3a: List gross charges for all residents by payer type. Gross charges must be reported from a uniform charge structure that is applicable to all residents. Revenue reported under Chart of Account numbers 5080 (Medical Supplies–Routine), 5100 (Medical Minor Equipment–Routine), and 5110 (Enteral Nutritional Therapy) must be distributed among all non-Medicare categories.

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

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

Section B: Costs

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

Line 6: Enter the corresponding costs from Schedules B-2 and C, column 3 in the appropriate column.

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

Section C: Ancillary/Support Cost-Offset

NOTE: Failure to complete Schedule A-2 will result in all Medicare Part B revenue being offset against direct care expenses on Schedule B-2, line 16.

6. Schedule B-1, Tax Costs (Columns 1–4)

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s).

Column 1: This column does not pertain to any account in this schedule.

Column 2: Report any appropriate non-wage expenses.

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

7. Schedule B-2, Direct Care Costs (Columns 1–3)

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to "Other Direct Care" line 13 and specify the detail in the spaces provided at the bottom of Schedule B-2, page 1 of 2. Provide supporting documentation as exhibits with cross references to applicable account number(s).

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

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

Column 3: Total of columns 1 and 2.

8. Schedule C, Ancillary/Support Costs (Columns 1–3)

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "Other/Contract Wages" column (2) for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "Other Ancillary/Support" line 63 and specify the detail in the spaces provided at the bottom of Schedule C, page 2 of 3. Provide supporting documentation as exhibits with cross references to applicable account number(s). Note that ambulance and wheelchair van transportation provided on or after January 1, 2014 can be billed directly to Medicaid by the transportation provider.

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

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

Column 3: Total of columns 1 and 2.

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

Complete per instructions on the form. This schedule should tie to Schedule E, (balance sheet) "Property, Plant and Equipment" section.

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

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

11. Schedule D (Column 3), Capital Cost Center

Complete per instructions on the form. NFs that did not change operator on or after July 1, 1993, should use group (A). NFs that did change operator on or after July 1, 1993, should use groups (A) and (B).

12. Attachment 2, Adjustment to Trial Balance

Columns 2 and 3, lines 1 through 20:

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

Column 5, lines 1 through 20:

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

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

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

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

13. Schedules B-1, B-2, C and D (Columns 4–7)

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

If no allocations are used, columns 6 and 7 need not be completed. If allocations are used, the allocation ratio should be calculated to four places to the right of the decimal.

14. Schedule C-1, Administrators Compensation

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

Section A:

Line 2: Work Experience

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

Line 3: Formal Education

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

Line 3.1: Baccalaureate Degree

For this administrator, record "Yes" if the administrator has obtained a baccalaureate degree. If the administrator has not obtained a baccalaureate degree, then record "No."

Line 4: Other Duties:

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

Include the following *other duties* in your count: accounting, maintenance and housekeeping. If the administrator performed any other duties, please complete the "Other, specify" lines.

For example, if the administrator performed laundry duties, then record as follows: Other, specify laundry.

Do not include any of the direct care duties listed below. If the administrator performed any of the eight duties listed below, complete page 1 of Schedule C-2. If the administrator is an owner or relative of the owner, complete page 2 also.

(a) Medical director
(b) Director of nursing
(c) Registered nurse (RN)
(d) Licensed practical nurse (LPN)
(e) Respiratory therapist
(f) Charge nurse; registered
(g) Charge nurse; licensed practical

Section B:

For each administrator complete the following:

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

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

Use account number 7600 or account number 7695, as appropriate. All administrators compensated through the home office use account 7695. All other administrators use account 7600.

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

If the administrator is an owner or relative of an owner, then complete Schedule C-2, page 2 of 2. Do not complete Schedule C-2, page 2 of 2 for a non-owner/administrator. Report the cost of all ancillary/support-related duties performed by administrator on Schedule C, line 44, account number 7600 or Schedule C, line 65, account number 7695, whichever is applicable.

The applicable Direct Care duties are:

(a) Medical Director;
(b) Director of Nursing;
(c) Registered Nurse (RN);
(d) Licensed Practical Nurse (LPN);
(e) Respiratory Therapist;
(f) Charge Nurse; Registered; and,
(g) Charge Nurse; Licensed Practical

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

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

Compensation may be reported as follows:

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

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Supersedes
TN 13-022 Effective 02/03/2016

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

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

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

15. Schedule C-2

Page 1 of 2:

List all owners and/or relatives who received compensation from this provider. Also, complete the schedule if any administrator wages are reported on Schedule B-2 for the direct care duties listed on page 20 of the instructions. This applies regardless of whether the administrator is a non-owner/administrator, an owner/administrator, or a relative of the owner.

Specify the name of person(s) claiming compensation, position number (see below), relationship to owner(s), years of experience in this field, dates of employment in this reporting period, number of hours worked in facility during the week, as well as the corresponding percentage of time worked at this facility, account number, and amount claimed for each person listed on the cost report. Social Security numbers are not required for non-profit or governmental facilities.

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

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

Page 2 of 2:

Except for non-owner administrators, for each individual identified above, list all the compensation received from other facilities participating in the Medicaid program (in Ohio and other states). Also, list any individual owning a 5% or more interest in this provider. Compensation claimed must be for

necessary services and related to resident care. Services rendered and compensation claimed must be reasonable based upon the time spent in performing the duty, and reasonable for the duty being performed.

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

Position Numbers for Corporate Officers

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

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

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

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

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

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

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

   CT01 - Corporate Treasurer 1 (1 - 99 beds)
   CT02 - Corporate Treasurer 2 (100 - 199)
   CT03 - Corporate Treasurer 3 (200 - 299)

CT04 - Corporate Treasurer 4 (300 - 599)
CT05 - Corporate Treasurer 5 (600 - 1199)
CT06 - Corporate Treasurer 6 (1200 +)

4. Board Secretary Series (BS)

BS01 - Corporate Board Secretary 1 (1 - 99 beds)
BS02 - Corporate Board Secretary 2 (100 - 199)
BS03 - Corporate Board Secretary 3 (200 - 299)

BS04 - Corporate Board Secretary 4 (300 - 599)
BS05 - Corporate Board Secretary 5 (600 - 1199)
BS06 - Corporate Board Secretary 6 (1200 +)

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Position Number for Owners/Relatives of Owner

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

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

WH Code	Title	Account	Schedule / Line
WH002	Medical Director	6100	Schedule B-2, Line 1
WH003	Director of Nursing	6105	Schedule B-2, Line 2
WH004	RN Charge Nurse	6110	Schedule B-2, Line 3
WH005	LPN Charge Nurse	6115	Schedule B-2, Line 4
WH006	Registered Nurse	6120	Schedule B-2, Line 5
WH007	Licensed Practical Nurse	6125	Schedule B-2, Line 6
WH008	Nurse Aides	6130	Schedule B-2, Line 7
WH016	Habilitation Staff	6170	Schedule B-2, line 8
WH019	Respiratory Therapist	6185	Schedule B-2, line 9
WH023	Quality Assurance	6205	Schedule B-2, line 10
WH066	Behavioral and Mental Health Services	6207	Schedule B-2, line 11
WH024	Other Direct Care Salaries - Specify	6220	Schedule B-2, line 13
WH025	Home Office Costs/Direct Care - Salary	6230	Schedule B-2, line 14
WH026	DO NOT USE THIS POSITION CODE		
WH027	In-House Trainer Wages	6500	Schedule B-2, line 27
WH028	Classroom Wages: Nurse Aides	6511	Schedule B-2, line 28
WH029	Clinical Wages: Nurse Aides	6521	Schedule B-2, line 29
WH030	Physical Therapist	6600	Schedule B-2, line 38
WH031	Physical Therapy Assistant	6605	Schedule B-2, line 39
WH032	Occupational Therapist	6610	Schedule B-2, line 40
WH033	Occupational Therapy Assistant	6615	Schedule B-2, line 41
WH034	Speech Therapist	6620	Schedule B-2, line 42
WH035	Audiologist	6630	Schedule B-2, line 43
WH063	EAP Administrator - Therapy	6643	Schedule B-2, line 47
WH064	Self Funded Program Admin.-Therapy	6644	Schedule B-2, line 48
WH065	Staff Development - Therapy	6645	Schedule B-2, line 49
WH036	EAP Administrator - Direct Care	6730	Schedule B-2, line 54
WH037	Self Funded Programs Admin. - Direct Care	6740	Schedule B-2, line 55
WH038	Staff Development - Direct Care	6750	Schedule B-2, line 56
WH039	Dietitian	7000	Schedule C, line 1

WH040	Food Service Supervisor	7005	Schedule C, line 2
WH041	Dietary Personnel	7015	Schedule C, line 3
WH042	EAP Administrator - Dietary	7075	Schedule C, line 15
WH043	Self-Funded Programs Administrator: Dietary	7080	Schedule C, line 16

WH Code	**Title**	**Account**	**Schedule / Line**
WH044	Staff Development - Dietary	7090	Schedule C, line 17
WH045	Medical/Habilitation Records	7105	Schedule C, line 19
WH046	Pharmaceutical Consultant	7110	Schedule C, line 20
WH009	Activity Director	7201	Schedule C, line 25
WH010	Activity Staff	7211	Schedule C, line 26
WH011	Recreational Therapist	7221	Schedule C, line 27
WH017	Psychologist	7231	Schedule C, line 28
WH018	Psychology Assistant	7241	Schedule C, line 29
WH020	Social Work/Counseling	7251	Schedule C, line 30
WH021	Social Services/Pastoral Care	7261	Schedule C, line 31
WH014	Habilitation Supervisor	7271	Schedule C, line 32
WH013	Program Director	7281	Schedule C, line 33
WH001	Water and Sewage	7511	Schedule C, line 39
WH047	DO NOT USE THIS POSITION CODE		
WH048	Other Administrative Personnel	7605	Schedule C, line 44
WH049	Security Services (Salary Only)	7625	Schedule C, line 48
WH050	Laundry/Housekeeping Supervisor	7635	Schedule C, line 51
WH051	Housekeeping	7640	Schedule C, line 52
WH052	Laundry and Linen	7645	Schedule C, line 53
WH053	Accounting	7655	Schedule C, line 55
WH054	Data Services (Salary Only)	7675	Schedule C, line 59
WH055	Other Ancillary/Support - Specify: (Salary)	7690	Schedule C, line 63
WH056	Home Office Costs/Ancillary/Support (Salary)	7695	Schedule C, line 64
WH057	DO NOT USE THIS POSITION CODE		
WH058	Plant Operations/Maintenance Supervisor	7700	Schedule C, line 66
WH059	Plant Operations and Maintenance	7710	Schedule C, line 67
WH060	EAP Administrator - Ancillary/Support	7830	Schedule C, line 76
WH061	Self-Funded Programs Admin. - Ancillary/Support	7840	Schedule C, line 77
WH062	Staff Development - Ancillary/Support	7850	Schedule C, line 78

16. Schedule C-3, Cost of Services from Related Organizations

Complete per instructions on the form. Social Security numbers are not required for non-profit or governmental facilities.

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

(1) An individual who is a relative of an owner is a related party.

(a) "Relative of owner" means an individual who is related to an owner of a facility by one of the following relationships:

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

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in both the provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.

(3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.

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

Corporation – An invisible, intangible, artificial creation of the law existing as a voluntary, chartered association of individuals that has most of the rights and duties of natural persons but with perpetual

existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest. In the ORC, unless a corporation is specified as nonprofit, it is assumed to be for-profit.

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

17. Schedule E, Balance Sheet

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

18. Schedule E-1, (Optional) Equity Capital of Proprietary Providers

Schedule E-1 (Optional) is provided for computing equity.

Lines 1 through 21 – Calculate equity.

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

19. Attachment 6, Wage and Hour Survey

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

NOTE: Wages are to include wages for sick pay, vacation pay, and other paid time off as well as any other compensation paid to the employee. Please do not include contract wages or negative wages on this form. Except as noted below, the amounts reported in column (C) must agree to the corresponding account numbers on Schedules B-2 and C, column 1.

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

20. Attachment 7, Addendum for Disputed Cost

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

21. Attachment 8, Employee Retention Rate

- Line 1 – Number of employees refers to the number of people on the payroll at the beginning of the cost reporting period. For example, an employee who works 20 hours per week is counted as one employee, just as one who works 40 hours per week.
- Line 2 – Of the employees counted in Line 1, the number still employed at the end of the cost reporting period.
- Line 3 – Round to 4 decimal places.
- Lines 4-6 – These lines are to be used for CY 2015 only. The answers are used to determine if a facility meets the employee retention quality indicator.
- Line 4 – Number of employees on the payroll that includes the date July 1, 2015.
- Line 5 – Of the employees counted in Line 4, the number still employed at the end of the cost reporting period.
- Line 6 – Round to 4 decimal places.

Preferences for Everyday Living Inventory (PELI) – In the Preferences for Everyday Living Inventory (PELI) section, indicate whether the nursing facility uses the PELI for all of its residents. The facility may use either the full or mid-level nursing home version of the PELI.

22. Attachment 3, Supplemental Information

Attach requested documentation as instructed.

23. Schedule A, Page 2 of 2, Certification by Officer of Provider

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

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

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

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

A. Check Box – If this section does not apply to this provider, check the box provided and skip to the certification section.

B. Chain Home Office Information – If there has been a change in the home office information since the previous cost reporting period, check "Change," and provide the effective date of the change.

Complete the appropriate fields in this section:

- Furnish the legal business name and tax identification number of the chain home office as reported to the IRS.

- Furnish the street address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.

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

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

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

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

Ohio Department of Medicaid
MEDICAID NURSING FACILITY COST REPORT

Type of Cost Report Filing. (Please check one of the following)
_____ 4.1 Year-End _____ 4.5 Final
_____ 4.2 New Facility _____ 4.6 Amended

INSTRUCTIONS: This cost report must be postmarked pursuant to Ohio Administrative Code. Failure to file timely will result in reduction of the current prospective rate by two dollars ($2.00) per patient per day. This rate reduction shall be adjusted for inflation in accordance with Ohio Revised Code. Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit a diskette or compact disc to Ohio Department of Medicaid, Deputy Director's Office, Cost Reporting Unit, P.O. Box 182709, Columbus, Ohio 43218-2709

Provider Name (DBA)	National Provider Identifier	Medicaid Provider Number	CMS Certification Number ## - ####
Complete Facility Address: Address (1) Address (2) City State of Ohio Zip Code		Federal Tax ID Number	Period Covered by Cost Report
		ODH ID Number	From:
		County	Through:

TYPE OF CONTROL OF PROVIDER (check one of the following:)

For Profit
____ Sole Proprietorship (1.1)
____ Partnership (1.2)
____ 1. General
____ 2. Limited
____ 3. Limited Liability Partnership
____ Corporation (1.3)
____ Publicly Traded Company (1.10)
____ Limited Liability Company (1.5)
____ Business Trust (1.6)
____ Other (Specify): _____ (1.4)

Location of Entity, Organization, or Incorporation:
If facility has a For Profit type of control, check one below:
____ Domestic (1.8)
____ Foreign (1.9) Location: _____

Non-Profit
____ Domestic Non-Profit Corporation (2.4)
____ Domestic Non-Profit LLC (2.7)
____ Foreign Non-Profit Corporation: Location: _____ (2.5)
____ Foreign Non-Profit LLC: Location: _____ (2.8)
____ Other (not yet defined "non-profit" entity) Specify: _____ (2.6)

Non-Federal Government
____ State (3.1)
____ County (3.2)
____ City (3.3)
____ City - County (3.4)
____ Other (Specify): _____ (3.6)

PROVIDER LEGAL ENTITY IDENTIFICATION
Name of Legal Entity
Address (1)
Address (2)
City
Zip Code State

NAME AND ADDRESS OF OWNER OF REAL ESTATE
Name
Address (1)
Address (2)
City
Zip Code State

PRACTICE TYPE
Check all that apply:
____ a. Physical Rehab Hospital Based
____ b. General/Acute Hospital Based
____ c. Long Term Acute Care Hospital (LTACH) Based
____ d. Continuing Care Retirement Center (CCRC) or Life Care Community
____ e. Other Assisted Living/Nursing Home Combination
____ f. Religious Non-Medical Health Care Institution (RNHCI)
____ g. Free Standing
____ h. Combined with ICF-MR and/or Outlier Unit
____ i. Other (Specify): _____

ALL PATIENTS	Medicaid Certified Beds Only (1)	Total Facility Licensed Beds (2)
1. Licensed beds at beginning of period		
** 2. Licensed beds at end of period		
3. Total bed days available		
4. Total inpatient days		
5. Percentage of occupancy (line 4 divided by line 3 X 100)		
6. Ancillary/Support allowable days (greater of line 4 or .9 X line 3)		
OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS		
7. Total patient days (from Schedule A-1, line 13, column-6)		
8. Utilization Rate (line 7 divided by line 4, col. 1 X 100)		

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

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

CHAIN HOME OFFICE/CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

CHAIN HOME OFFICE INFORMATION

This section is to be completed with information about the "HOME OFFICE" for those providers that are members of, or are joining, a chain organization.

A. If this section does not apply check here _____

B. Chain Home Office Information _____ Change Effective Date :

1. Name of Home Office as Reported to the IRS		Federal Tax ID Number
2. Home Office Business Street Address Line 1		
Home Office Business Street Address Line 2		
City	State	ZIP Code

C. Provider's Affiliation to the Chain Home Office _____ Change Effective Date :

Check the appropriate box:

1. _____ Joint Venture / Partnership
2. _____ Operated / Related
3. _____ Managed / Related
4. _____ Wholly Owned
5. _____ Leased
6. _____ Other (Specify): _____

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18 all cost reports submitted to the Ohio Department of Medicaid will be certified as follows:

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

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

Signature of Owner, Officer, or Authorized Representative of Provider		Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider (Last) (First) (M.I.)		
Title	Telephone Number Area code ( )	Email Address

Report Prepared by (Company)		
Report Prepared by (Individual) (Last) (First) (M.I.)		Title
Address		
City, State, Zip Code		
Telephone Number of Person Preparing Cost Report Area Code ( )		Email Address

Location of Records or Probable Audit Site		Telephone Number for Audit Contact Person Area Code ( )
Address		County
City	State	Zip Code

NOTARIZED

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

Signature of Notary

ODM 02524N (REV. 12/2015)

Schedule A-1

SUMMARY OF INPATIENT DAYS

Provider Name	Medicaid Provider Number		Reporting Period From: Through:

INSTRUCTIONS: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. Nursing facilities must report each medically necessary leave day and limited absence as either 50% or 18% of an inpatient day. Please refer to the Ohio Administrative Code for details.

	Number of Medicaid Certified Beds (1)	Medicaid Patients						Non-Medicaid Patients				Total Inpatient Days (sum cols. 6-11) (12)
		Fee-For-Service Days (2)	MyCare Medicaid Days (3)	Hospital Leave Days (@ 50%) (4)	Therapeutic Leave Days (@ 50%) (5)	Total Medicaid Days (sum cols. 2-5) (6)	Managed Care Days (7)	Private Days (8)	Medicare Days (9)	MyCare Medicare Days (10)	Veterans and Other Days (11)	
1. Jan												
2. Feb												
3. Mar												
4. Apr												
5. May												
6. Jun												
7. Jul												
8. Aug												
9. Sep												
10. Oct												
11. Nov												
12. Dec												
13. TOTAL sum of lines 1 through 12												
						Schedule A, page 1, line 7, column 2						Schedule A, page 1, line 4, column 1

Note: Round all leave days to two decimal places.

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Schedule A-2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

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

Description	Medicare Part B Primary Payer is:		Private	Medicare Part A Services	Veteran and Other	Medicaid	Total Revenue (sum of columns 2 through 7)
SECTION A: REVENUES	Medicaid	Other					
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1a. Medical Supplies Revenue							
1b. Percent of Medical Supplies Revenue by Payer Source							100%
2a. Medical Minor Equipment Revenue							
2b. Percent of Medical Minor Equipment Revenue by Payer Source							100%
3a. Enteral Feeding Revenue							
3b. Percent of Enteral Feeding Revenue by Payer Source							100%
4. Total Revenue by Payer Source							

	MEDICARE PART B OFFSET CALCULATIONS			
SECTION B: COSTS	Medical Supplies	Medical Minor Equip.	Enterals	Total Offset
(1)	(2)	(3)	(4)	(5)
5. Percentage of Medicare Part B charges where primary payer is Medicaid (from Schedule A-2, column 2, applicable line b)				
6. Costs (from Schedule B-2, line 16, column 3, and Schedule C, lines 10 and 35, column 3)				
7. Costs to be offset (line 5 times line 6). Offset costs in column 4 on the schedules and lines identified in line 6 above.				
SECTION C: ANCILLARY/SUPPORT COSTS - OFFSET				
8. Ancillary/Support costs (Schedule C, line 80, column 3 less Schedule C, lines 18, 24, 51, 52, 53 and 72, column 3)				
9. Total costs (total of Schedule B-1, line 5, Schedule B-2, line 58, Schedule C, line 80, Schedule D, lines 12 and 18, column 3)				
10. Ancillary/Support costs as a percent of total costs (line 8 divided by line 9)				
11. Costs offset (from line 7 column 5 above)				
12. Ancillary/Support costs to be offset (line 10 times line 11) offset costs on Schedule C line 63 column 4				

SUMMARY OF COSTS

Schedule A-3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REIMBURSABLE COSTS	Schedule Reference Line (1)	Sub Total (2)	Total Cost (3)
TAX COST CENTER			
1. Tax Cost	B-1 line 5 Col 7		
DIRECT CARE COST CENTER			
2. Direct Care Cost	B-2 line 58 Col 7		
ANCILLARY/SUPPORT COST CENTER			
3. Ancillary/Support Cost	C line 80 Col 7		
CAPITAL COST CENTER			
4. Assets Acquired Group A	D line 12 Col 7		
5. Assets thru Change of Operator Group B	D line 18 Col 7		
6. TOTAL CAPITAL COST (Sum of lines 4 and 5) Col 2			
7. TOTAL REIMBURSABLE COSTS (sum of lines 1, 2, 3 and 6) Col 3			

RECONCILIATION OF COSTS

Schedule / Line #		Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
8.	B1/5	col 3	col 4	col 5	col 7
9.	B2/58	col 3	col 4	col 5	col 7
10.	C/96	col 3	col 4	col 5	col 7
11.	D/12	col 3	col 4	col 5	col 7
12.	D/18	col 3	col 4	col 5	col 7
13.	**Totals**	$ (A)	$ (B)	$	$
14. Less Non-reimbursable from Schedule C, page 3, line 95				col 5 ( )	col 7 ( )
15. Total Reimbursable				$	$ (C)

(A) Agrees to Total Expenses per Working Trial Balance.
(B) Agrees to Attachment 2, line 21, column 4, and Schedule A-2, lines 7 and 12, column 5.
(C) Agrees to Schedule A-3, line 7, column 3.

NOTE: Round all cost data to the nearest whole dollar.

TAX COSTS

Schedule B-1

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

TAX COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
1. Real Estate Taxes	6060							
2. Personal Property Taxes	6070							
3. Franchise Tax (Attach FT 1120)	6080							
4. Commercial Activity Tax (CAT)	6085							
5. TOTAL Tax Costs (sum of lines 1 through 4)								

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

Note: Round all cost data to the nearest whole dollar.

DIRECT CARE COSTS

Schedule B-2
1 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	NURSING AND HABILITATION/REHABILITATION								
1.	Medical Director	6100							
2.	Director of Nursing	6105							
3.	RN Charge Nurse	6110							
4.	LPN Charge Nurse	6115							
5.	Registered Nurse	6120							
6.	Licensed Practical Nurse	6125							
7.	Nurse Aides	6130							
8.	Habilitation Staff	6170							
9.	Respiratory Therapist	6185							
10.	Quality Assurance	6205							
11.	Behavioral and Mental Health Services	6207							
12.	Consulting and Management Fees - Direct	6210							
13.	Other Direct Care - Specify below	6220							
14.	Home Office Costs/Direct Care **	6230							
15.	**TOTAL Nursing and Habilitation/Rehabilitation** (sum of lines 1 through 14)								
	MEDICAL, HABILITATION, AND UNIVERSAL PRECAUTION SUPPLIES								
16.	Medical Supplies - Medicare Billable	6301							
17.	Medical Supplies - Medicare Non-Billable	6311							
18.	Oxygen - Emergency stand-by	6321							
19	Oxygen - other than Emergency stand-by (only through 12/31/13)	6322							
20	Habilitation Supplies	6330							
21	Universal Precaution Supplies	6340							
22	**TOTAL Medical, Habilitation, and Universal Precaution Supplies** (sum of lines 16 through 21)								
	PURCHASED NURSING SERVICES								
23	Registered Nurse - Purchased Nursing	6401							
24	Licensed Practical Nurse - Purchased Nursing	6411							
25	Nurse Aides - Purchased Nursing	6421							
26	**TOTAL Purchased Nursing** (sum of lines 23 through 25)								

Line 13 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 13, Columns 1 and 2)		

** Enter home office costs on line 14 only. They are not to be distributed to any other line on this schedule.

*** If allocation is used, calculate the allocation ratio to four places to the right of the decimal.

Note: Round all cost data to the nearest whole dollar.

DIRECT CARE COSTS

Schedule B-2
2 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	DIRECT CARE COSTS	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	NURSE AIDE TRAINING								
27	In-House Trainer Wages	6500							
28	Classroom Wages - Nurse Aides	6511							
29	Clinical Wages - Nurse Aides	6521							
30	Books and Supplies	6531							
31	Transportation	6541							
32	Tuition Payments	6551							
33	Tuition Reimbursement	6560							
34	Contractual Payments to Other NFs	6570							
35	Registration Fees/Application Fees	6580							
36	Employee Fringe Benefits	6590							
37	**TOTAL Nurse Aide Training** (sum of lines 27 through 36)								
	DIRECT CARE THERAPIES								
38	Physical Therapist	6600							
39	Physical Therapy Assistant	6605							
40	Occupational Therapist	6610							
41	Occupational Therapy Assistant	6615							
42	Speech Therapist	6620							
43	Audiologist	6630							
44	Payroll Taxes - Therapy	6640							
45	Workers' Compensation - Therapy	6650							
46	Employee Fringe Benefits - Therapy	6660							
47	EAP Administrator - Therapy	6665							
48	Self Funded Program Admin. - Therapy	6670							
49	Staff Development - Therapy	6680							
50	**TOTAL Direct Care Therapies** (sum of lines 38 through 49)								
	PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT (No Purchased Nursing)								
51	Payroll Taxes - Direct Care	6700							
52	Worker's Compensation - Direct Care	6710							
53	Employee Fringe Benefits - Direct Care	6720							
54	EAP Administrator - Direct Care	6730							
55	Self Funded Programs Admin. - Direct Care	6740							
56	Staff Development - Direct Care	6750							
57	**TOTAL Payroll Taxes, Fringe Benefits, and Staff Development** (sum of lines 51 through 56)								
58	**TOTAL REIMBURSABLE DIRECT CARE COST** (sum of lines 15, 22, 26, 37, 50 and 57)								

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

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

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Supersedes
TN 13-022 Effective 02/03/2016

ANCILLARY/SUPPORT COSTS

Schedule C
1 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
DIETARY COST								
1. Dietitian	7000							
2. Food Service Supervisor	7005							
3. Dietary Personnel	7015							
4. Dietary Supplies and Expenses	7025							
5. Dietary Minor Equipment	7030							
6. Dietary Maintenance and Repair	7035							
7. Food In-Facility	7040							
8. Employee Meals	7045							
9. Contract Meals/Contract Meals Personnel	7050							
10. Enterals: Medicare Billable	7055							
11. Enterals: Medicare Non-Billable	7056							
12. Payroll Taxes - Dietary	7060							
13. Workers' Compensation - Dietary	7065							
14. Employee Fringe Benefits - Dietary	7070							
15. EAP Administrator - Dietary	7075							
16. Self Funded Programs Admin. - Dietary	7080							
17. Staff Development - Dietary	7090							
18. TOTAL Dietary (sum of lines 1 through 17)								
MEDICAL RECORDS, PHARMACY, AND SUPPLIES								
19. Medical/Habilitation Records	7105							
20. Pharmaceutical Consultant	7110							
21. Incontinence Supplies	7115							
22. Personal Care - Supplies	7120							
23. Program Supplies	7125							
24. TOTAL Medical Records, Pharmacy, and Supplies (sum of lines 19 through 23)								
ACTIVITIES, HABILITATION, AND SOCIAL SERVICES								
25. Activity Director	7201							
26. Activity Staff	7211							
27. Recreational Therapist	7221							
28. Psychologist	7231							
29. Psychology Assistant	7241							
30. Social Work/Counseling	7251							
31. Social Services/Pastoral Care	7261							
32. Habilitation Supervisor	7271							
33. Program Director	7281							
34. TOTAL Activities, Habilitation, and Social Services (sum of lines 25 through 33)								
MEDICAL MINOR EQUIPMENT								
35. Medical Minor Equip. - Medicare Billable	7301							
36. Medical Minor Equip. - Medicare Non-Billable	7302							
37. TOTAL Medical Minor Equipment (sum of lines 35 through 36)								
UTILITY COSTS								
38. Heat, Light, Power	7501							
39. Water and Sewage	7511							
40. Trash and Refuse Removal	7521							
41. Hazardous Medical Waste Collection	7531							
42. TOTAL Utility Costs (sum of lines 38 through 41)								

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.
Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Schedule C
2 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

	ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other/ Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	ADMINISTRATIVE AND GENERAL SERVICES								
43.	Administrator	7600							
44	Other Administrative Personnel	7605							
45.	Consulting and Management Fees - Ancillary/Support	7610							
46.	Office and Administrative Supplies	7615							
47.	Communications	7620							
48.	Security Services	7625							
49.	Travel and Entertainment	7630							
50	Resident Transportation (only through 12/31/13)	7631							
51	Laundry/Housekeeping Supervisor	7635							
52	Housekeeping	7640							
53	Laundry and Linen	7645							
54	Legal Services	7650							
55	Accounting	7655							
56	Dues, Subscriptions and Licenses	7660							
57	Interest - Other	7665							
58	Insurance	7670							
59	Data Services	7675							
60	Help Wanted/Informational Advertising	7680							
61	Amortization of Start-Up Costs	7685							
62	Amortization of Organizational Costs	7686							
63	Other Ancillary/Support - Specify below	7690							
64	Home Office Costs - Ancillary/Support **	7695							
65	**TOTAL Administative and General Services** (sum of lines 43 through 64)								
	MAINTENANCE AND MINOR EQUIPMENT								
66	Plant Operations/Maintenance Supervisor	7700							
67	Plant Operations and Maintenance	7710							
68	Repair and Maintenance	7720							
69	Minor Equipment	7730							
70	Custom Wheelchairs (only through 12/31/13)	7735							
71	Leased Equipment	7740							
72	**TOTAL Maintenance and Minor Equipment** (sum of lines 66 through 71)								
	PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT								
73	Payroll Taxes - Ancillary/Support	7800							
74	Workers' Compensation - Ancillary/Support	7810							
75	Employee Fringe Benefits - Ancillary/Support	7820							
76	EAP Administrator - Ancillary/Support	7830							
77	Self Funded Prog. Admin. - Ancillary/Support	7840							
78	Staff Development - Ancillary/Support	7850							
79	**TOTAL Payroll Taxes, Fringe Benefits, and Staff Development** (sum of lines 74 through 79)								
80	**TOTAL Reimbursable Ancillary/Support Cost** (sum of lines 18, 24, 34, 37, 42, 65, 72, and 79)								

** Home office costs are to be entered on line 65 only. They are not to be distributed to any other line on this schedule.

Line 63 Other Ancillary/Support

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 63, Columns 1 and 2)		

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.
Note: All cost data should be rounded to the nearest whole dollar.

ANCILLARY/SUPPORT COSTS

Schedule C
3 of 3

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

	ANCILLARY/SUPPORT	Chart of Acct	Salary Facility Employed (1)	Other / Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
	NON-REIMBURSABLE EXPENSES								
81	Legend Drugs	9705							
82	Radiology	9710							
83	Laboratory	9715							
84	Non-Emergency Oxygen (on or after 1/1/2014)	9720							
85	Other Non-Reimbursable - Specify below	9725							
86	Late Fees, Fines or Penalties	9730							
87	Federal Income Tax	9735							
88	State Income Tax	9740							
89	Local Income Tax	9745							
90	Insurance - Officers' Life	9750							
91	Promotional Advertising and Marketing	9755							
92	Contributions and Donations	9760							
93	Bad Debt	9765							
94	Parenteral Nutrition Therapy	9770							
95	Franchise Permit Fees	9776							
96	**TOTAL Non-Reimbursable Expenses** (sum of lines 81 through 95)								
97	**TOTAL Ancillary/Support Cost Reimbursable and Non-Reimbursable** (sum of lines 80 and 96)								

Line 85 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 85, Columns 1 and 2)		

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

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

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ADMINISTRATORS' COMPENSATION

Schedule C-1

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

SECTION A:

First Name of Administrator	Last Name of Administrator	Administrator License Number*	Social Security Number

Relationship to Provider
Is the administrator an owner or a relative? _____ Yes _____ No

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

SECTION B:

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

* Administrators of hospital based nursing facilities report Social Security number.

** Report the number of hours consistent with the amount of compensation reported. If the amount in column (7) is allocated, hours paid must be allocated using the same ratio.

*** This schedule must be completed for all administrators regardless of whether the administrator's salary is reported in account number 7600 or account number 7695. (Use only account number 7600 or 7695, whichever is appropriate.)

OWNERS' / RELATIVES' COMPENSATION
OTHER THAN COMPENSATION FOR FACILITY ADMINISTRATOR DUTIES

Schedule C-2
1 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: If no compensation is reported do not complete this form, otherwise all items within this schedule must be completed. However, Social Security numbers are not required for non-profit or governmental facilities. Detail owners' and/or relatives' compensation included on Schedules B-2 and C net of applicable Column 4 adjustments.

Individual's Name	Social Security Number	Position Number **	Relationship to Owner	Years of Exper.	Dates of Employment During this Reporting Period		Paid Weekly		Compensation		
					Beginning	Ending	Hours *	%	Account Number	Col. No.	Amount
(1)	(2)	(3)	(4)	(5)	(6)	(6)	(8)	(9)	(10)	(11)	(12)

* Report the number of hours consistent with the amount of compensation reported. If the amount in column 12 is allocated, hours paid must be allocated the same way.

** See cost report instructions: pages 23, 24, and 25 for position numbers.

OWNERS'/RELATIVES' COMPENSATION

Schedule C-2
2 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: All items within this schedule must be completed. However, Social Security numbers are not required for non-profit or governmental facilities. List all compensation received from other long-term care facilities in the Medicaid program (in Ohio or other states) by persons listed on Schedule C-2, page 1 of 2, and/or owning a 5% or more interest in this facility.

Individual's Name	Social Security Number	Facility Name	Number of Beds	Medicaid Provider Number	Paid Weekly		Amount of Compensation
					Hours *	%	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)

* Report the number of hours consistent with the amount of compensation reported. If the amount in column 8 is allocated, hours paid must be allocated the same way.

COST OF SERVICES FROM RELATED PARTIES

Schedule C-3
1 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

1. In the amount of costs to be reimbursed by the Ohio Medicaid program, are any costs included which are a result of transactions with a related party? *

Yes _____ No _____ If yes, complete item 2.

2. Does this cost report include payments to related parties in excess of the costs to the related party?

Yes _____ No _____ If yes, complete the table below.

Name of Owner (1)	Social Security No. (2)	Name of Related Party (3)	Federal ID. No. (4)	Percent Ownership (5)	Account Number (6)	Item (7)	Actual Cost Claimed on this Cost Report (8)	Cost to Related Party (9)

* For further explanation see Ohio Administrative Code.

Note: Social Security numbers are not required for non-profit or governmental facilities.

COST OF SERVICES FROM RELATED PARTIES

Schedule C-3
2 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

3. List each individual, partner, related corporation, or related LLC that owns, in whole or in part, any mortgage or deed of trust of the facility or of any property or asset of the provider. (All individuals owning greater than 10% of the land or building, and/or greater than 5% of non real estate business, etc., must be identified by name and Social Security number.) * Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Title/Position (if applicable)	% Ownership	SSN or Fed ID #	Address	State	Zip Code

4. List all persons performing the duties of officer, director or equivalence (President, VP, Secretary, or other related positions). Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Job Title (if applicable)

5. List all other facilities that have related ownership as set forth in Section 5111.20 of the ORC.

Provider Name	Provider Number	Number of Beds	Provider Name	Provider Number	Number of Beds

* For further explanation see Ohio Administrative Code.

COST OF GOODS OR SERVICES FROM RELATED PARTIES

Schedule C-3
3 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

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

Yes _____ No _____ If yes, list names below: Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Name	Social Security Number

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

Yes _____ No _____ If yes, list names below: Note: Social Security numbers are not required for non-profit and governmental facilities.

Name	Social Security Number	Name	Social Security Number

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

Contractor Name	Contract Amount	Goods or Services Provided

CAPITAL COSTS

Schedule D

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.
Facilities that did change operator on or after 7/01/93 use groups A and B.

GROUP A **ASSETS ACQUIRED**

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant & Equip.	8070					
9. Amortization of Financing Costs	8080					
10. Nonextensive Renovations - Depreciation/Amortization and Interest	8085, 8086, 8087					
11. Home office costs - capital **	8090					
12. TOTAL Capital Costs Group A						

** Home Office Costs are to be entered on line 11 only. They are not to be distributed to any other line in Group A.

GROUP B **ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR**

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.
Leased facilities that changed operator on or after 5/27/92 use this group to report expenses incurred through a change of operator on or after 5/27/92.
[Use column (4) to adjust reported costs to the allowable costs as defined in Ohio Administrative Code.]

CAPITAL COSTS (1)	Chart of Account (2)	Total (3)	Adjustment Increase (Decrease) (4)	Adjusted Total [Col 3 + Col 4] (5)	Alloc. *** (6)	Allocated Adjusted Total [Col 5 x Col 6] (7)
13. Depreciation - Building	8110					
14. Depreciation - Equipment	8140					
15. Interest Exp. - Prop., Plant & Equip.	8170					
16. Amortization of Financing Costs	8180					
17. Lease Expense	8195					
18. TOTAL Capital Costs Group B						

*** If allocation is used, the allocation ratio should be calculated to four places to the right of the decimal.

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

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT

Schedule D-1

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: Facilities that did not change operator on or after 7/01/93 need only use group A.
Facilities that did change operator on or after 7/01/93 use groups A and B.

GROUP A

ASSETS ACQUIRED

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

NONEXTENSIVE RENOVATIONS

INSTRUCTIONS: Complete for nonextensive renovations in use during cost report period and completed prior to 7/1/05.

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

GROUP B

ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR

INSTRUCTIONS: Facilities, other than leased facilities, that changed operator on or after 7/01/93 use this group to report expenses incurred through a change of operator on or after 7/01/93.

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (Col 2 + Col 3) (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (Col 2 - Col 5) (6)	Depreciation this Period (7)
11. Land							
12. Buildings							
13. Equipment							
14. Financing Costs							
15. TOTAL							

Has there been any change in the original historical cost of capital assets? _____ YES _____ NO

If yes, submit complete detail.

CAPITAL ADDITIONS/DELETIONS

Schedule D-2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: The completion of this schedule is optional if the detailed depreciation schedule submitted contains all the information required in D-2 with the exception of columns 8 and 11. Entries into columns 12 and 13 are mandatory only in the event of asset deletions.

Asset Description (1)	Asset Account Title (2)	Date Acquired (MM/DD/YY) (3)	Date Disposed (MM/DD/YY) (4)	Method of Deprec. (5)	Acquisition Cost (6)	Useful Life (7)	Annual Depreciation (8)	Depreciation for C/R Period (9)	C/R Period Ending Accum Depreciation (10)	Net Book Value (11)	Sales Price (12)	Gain or (Loss) on Disposal (13)
TOTAL												

NOTE: Columns 6, 9, 10, and 11 should tie to Schedule D-1 Capital Cost for each column.

BALANCE SHEET

Schedule E

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

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

Line 33 Other Liabilities

Account Title	Beginning of Period	End of Period
TOTALS (must tie to line 33)		

EQUITY CAPITAL OF PROPRIETARY PROVIDERS Schedule E-1

This Schedule is Optional

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

SECTION A: TOTAL EQUITY

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

REVENUE TRIAL BALANCE

Attachment 1
1 of 3

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REVENUE ACCOUNT NAME		Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
	ROUTINE SERVICE - ROOM AND BOARD				
1.	Private	5010			
2.	Medicare	5011			
3.	Medicaid	5012			
4.	Veterans	5013			
5.	Other	5014			
6.	**TOTAL Routine Service - Room and Board** (lines 1 through 5)				
	DEDUCTIONS FROM REVENUES				
7.	Contractual Allowance-Medicare	5710			
8.	Contractual Allowance-Medicaid	5720			
9.	Contractual Allowance-Other	5730			
10.	Charity Allowance	5740			
11.	**TOTAL Deductions from Revenues** (lines 7 through 10)				
	THERAPY SERVICES				
12.	Physical Therapy	5020			
13.	Occupational Therapy	5030			
14.	Speech Therapy	5040			
15.	Audiology Therapy	5050			
16.	Respiratory Therapy	5060			
17.	**TOTAL** (lines 12 through 16)				
	MEDICAL SUPPLIES				
18.	Medicare B - Medicaid To Sch. A-2, Line 1a, Col. 2	5070-1			
19.	Medicare B - Other To Sch. A-2, Line 1a, Col. 3	5070-2			
20.	Private To Sch. A-2, Line 1a, Col. 4	5070-3			
21.	Medicare A To Sch. A-2, Line 1a, Col. 5	5070-4			
22.	Veterans To Sch. A-2, Line 1a, Col. 6	5070-5			
23.	Other To Sch. A-2, Line 1a, Col. 6	5070-6			
24.	Medicaid To Sch. A-2, Line 1a, Col. 7	5070-7			
25.	Medical Supplies - Routine	5080			
26.	Habilitation Supplies	5085			
27.	**TOTAL Medical Supplies** (lines 18 through 26)				
	MEDICAL MINOR EQUIPMENT				
28.	Medicare B - Medicaid To Sch. A-2, Line 2a, Col. 2	5090-1			
29.	Medicare B - Other To Sch. A-2, Line 2a, Col. 3	5090-2			
30.	Private To Sch. A-2, Line 2a, Col. 4	5090-3			
31.	Medicare A To Sch. A-2, Line 2a, Col. 5	5090-4			
32.	Veterans To Sch. A-2, Line 2a, Col. 6	5090-5			
33.	Other To Sch. A-2, Line 2a, Col. 6	5090-6			
34.	Medicaid To Sch. A-2, Line 2a, Col. 7	5090-7			
35.	Medical Minor Equipment - Routine	5100			
36.	**TOTAL Medical Minor Equipment** (lines 28 through 35)				

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REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

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

Line 59 Other

Account Title	Amount
TOTAL (must tie to line 59, Column 2)	

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REVENUE TRIAL BALANCE

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

REVENUE ACCOUNT NAME	Chart of Account (1)	Total (2)	Adjustments Increase (Decrease) (3)	Adjusted Total (Col. 2 + Col. 3) (4)
NON-OPERATING				
61. Management Services	5510			
62. Cash Discounts	5520			
63. Rebates and Refunds	5530			
64. Gift Shop	5540			
65. Vending Machine Revenues	5550			
66. Vending Machine Commissions	5555			
67. Rental - Space	5560			
68. Rental - Equipment	5570			
69. Rental - Other	5580			
70. Interest Income - Working Capital	5590			
71. Interest Income - Restricted Funds	5600			
72. Interest Income - Funded Depreciation	5610			
73. Interest Income - Related Party Revenue	5620			
74. Interest Income - Contributions	5625			
75. Endowments	5630			
76. Gain / Loss on Disposal of Assets	5640			
77. Gain / Loss on Sale of Investments	5650			
78. Nurse Aide Training Program Revenue	5660			
79. Contributions	5670			
80. TOTAL Non-operating (lines 61 through 79)				
81. TOTAL (Sum of Lines 6, 11, 17, 27, 36, 45, 49, 60 and 80)				

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ADJUSTMENT TO TRIAL BALANCE

Attachment 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

DESCRIPTION	Revenue Chart of Account Number (1)	Salary Increase (Decrease) (2)	Other Increase (Decrease) (3)	Total Increase (Decrease) (Col. 2 + Col. 3) (4)	Expense Chart of Account Number (5)	Revenue Reference Attachment 1 Line (6)
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21. TOTAL						

MEDICAID COST REPORT SUPPLEMENTAL INFORMATION

Attachment 3

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:

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

Please attach one copy of the following:

Exhibit 1. Facility trial balance that details the general ledger account names as of December 31, 20CY.

IF THE CHART OF ACCOUNTS IN APPENDIX A OF OHIO ADMINISTRATIVE CODE RULE 5160-3-42 IS NOT USED, IT IS THE RESPONSIBILITY OF THE PROVIDER TO RELATE ITS CHART OF ACCOUNTS DIRECTLY TO THE COST REPORT.
(One copy with each cost report is required.)

Exhibit 2. Complete and detailed depreciation schedules in a format as defined on schedule D-2 of this cost report. (One copy with each cost report is required.)

Exhibit 3. Home office trial balances and the allocation work sheets that show how the home office trial balance is allocated to each individual facility's cost report.
Include the account groupings for each home office account. The allocation procedures are pursuant to CMS Publication 15-1, (If applicable – one copy with each cost report is required.)

Exhibit 4. Copies of the Franchise Tax forms to support any Franchise Taxes reported.
(If applicable – one copy with each cost report is required.)

Exhibit 5. Any other documentation which is necessary to explain costs.
Identify exhibits with cross references to applicable schedule and line number or item, example: Exhibit 5 references Schedule C, line 8, col. 4.

Failure to cross-reference exhibits, to the applicable cost report schedule, line, and column qualify this report as being incomplete. Incomplete filings can result in penalties applied pursuant to Ohio Administrative Code.

WAGE AND HOURS SURVEY

Attachment 6
1 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through

INSTRUCTIONS: Report the number of hours consistent with the amount of compensation reported.

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

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

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

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

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

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

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
DIRECT CARE NURSING AND HABILITATION / REHABILITATION							
1. Medical Director	6100						
2. Director of Nursing	6105						
3. RN Charge Nurse	6110						
4. LPN Charge Nurse	6115						
5. Registered Nurse	6120						
6. Licensed Practical Nurse	6125						
7. Nurse Aides	6130						
8. Habilitation Staff	6170						
9. Respiratory Therapist	6185						
10. Quality Assurance	6205						
11. Behavioral and Mental Health Services	6207						
12. Consulting and Management Fees-Direct	6210						
13. Other Direct Care - Specify below	6220						
14. Home Office Costs/Direct Care (salary)	6230						
15. TOTAL Nursing and Habilitation / Rehabilitation (sum of lines 1 through 14)							
NURSE AIDE TRAINING							
16. In-House Trainer Wages	6500						
17. Classroom Wages: Nurse Aides	6511						
18. Clinical Wages: Nurse Aides	6521						
19. TOTAL Nurse Aide Training (sum of lines 16 through 18)							
DIRECT CARE THERAPIES							
20. Physical Therapist	6600						
21. Physical Therapy Assistant	6605						
22. Occupational Therapist	6610						
23. Occupational Therapy Assistant	6615						
24. Speech Therapist	6620						
25. Audiologist	6630						
26. EAP Administrator - Therapy	6665						
27. Self-Funded Program Admin. - Therapy	6670						
28. Staff Development - Therapy	6680						
29. TOTAL Direct Care Therapies (sum of lines 20 through 28)							
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - DIRECT CARE							
30. EAP Administrator - Direct Care	6730						
31. Self-funded Programs Administrator - Direct Care	6740						
32. Staff Development - Direct Care	6750						
33. TOTAL Payroll Tax, Fringe Benefits, and Staff Development (sum of lines 30 through 32)							
34. TOTAL Page 1 (sum of lines 15, 19 , 29 and 33)							

WAGE AND HOURS SURVEY

Attachment 6
2 of 2

Provider Name	Medicaid Provider Number	Reporting Period From: Through

WAGE COST CENTERS (A)	Chart of Acct (B)	Total Wages Paid (C)	Owners Wages Paid (D)	Total Non-owner Wages Paid (E)	Total Hours Paid (F)	Owners Hours Paid (G)	Total Non-owner Hours Paid (H)
ANCILLARY/SUPPORT DIETARY COST							
35 Dietitian	7000						
36 Food Service Supervisor	7005						
37 Dietary Personnel	7015						
38 EAP Administrator - Dietary	7075						
39 Self Funded Programs Admin - Dietary	7080						
40 Staff Development - Dietary	7090						
41 TOTAL Dietary (sum of lines 35 through 40)							
HABILITATION AND PHARMACEUTICAL							
42 Medical/Habilitation Records	7105						
43 Pharmaceutical Consultant	7110						
44 TOTAL Habilitation and Pharmaceutical (sum of lines 42 and 43)							
ACTIVITIES, HABILITATION, AND SOCIAL SERVICES							
45 Activity Director	7201						
46 Activity Staff	7211						
47 Recreational therapist	7221						
48 Psychologist	7231						
49 Psychology Assistant	7241						
50 Social Work/Counseling	7251						
51 Social Services/Pastoral Care	7261						
52 Habilitation Supervisor	7271						
53 Program Director	7281						
54 TOTAL Activities, Habilitation, and Social Services (sum of lines 45 through 53)							
UTILITIES							
55 Water and Sewage (salary only)	7511						
ADMINISTRATIVE AND GENERAL SERVICES							
56 Administrator	7600						
57 Other Administrative Personnel	7605						
58 Security Services - (salary only)	7625						
59 Resident Transportation (only through 12/31/13)	7631						
60 Laundry/Housekeeping Supervisor	7635						
61 Housekeeping	7640						
62 Laundry and Linen	7645						
63 Accounting	7655						
64 Data Services (salary only)	7675						
65 Other Ancillary/Support (salary only)	7690						
66 Home Office Ancillary Care Salary	7695						
67 TOTAL Administrative and General Services (sum of lines 56 through 66)							
MAINTENANCE PERSONNEL							
68 Plant Operations Maintenance Supervisor	7700						
69 Plant Operations and Maintenance	7710						
70 TOTAL Maintenance Personnel (sum of lines 68 and 69)							
PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - ANCILLARY/SUPPORT							
71 EAP Administrator - Ancillary/Support	7830						
72 Self Funded Prog. Admin.- Ancillary/Support	7840						
73 Staff Development - Ancillary/Support	7850						
74 TOTAL Payroll Taxes, Fringe Benefits, and Staff Development - Ancillary/Support (sum of lines 71 thru 73)							
75 TOTAL Page 2 (sum of lines 41, 44, 54, 55, 67, 70, and 75)							
76 TOTAL ATTACHMENT 6 Pages 1 and 2 (sum of lines 34 and 75)							

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ADDENDUM FOR DISPUTED COSTS

Attachment 7

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

INSTRUCTIONS: This attachment is for the reporting of costs as specified in the Ohio Revised Code that the provider believes should be classified differently than required on the cost report.

1. Enter in the "Reclassification From" columns the specific account title and chart number as entered on the cost report, as well as costs applicable to columns 1 through 3.

2. Enter in the "Reclassification To" columns the schedule, line number, and reason you believe these costs should be reclassified.

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

Employee Retention Rate

Provider Name	Medicaid Provider Number	Reporting Period From: Through:

1. Number of employees on first full payroll ending date of the cost reporting period _____
2. Of those in Line 1, number of employees on last payroll ending date of the cost reporting period remaining from Line 1 _____
3. Employee Retention Rate ((Line 2 divided by Line 1)*100%) _____

For CY 2015 Only:

4. Number of employees on the payroll that includes the date 7-1-2015. _____
5. Of those in Line 4, number of employees on last payroll ending date of the cost reporting period _____
6. Employee Retention Rate ((Line 5 divided by Line 4)*100%) _____

Preferences for Everyday Living Inventory (PELI)

Does the nursing facility utilize the full or mid-level nursing home version of the Preferences for Everyday Living Inventory (PELI) for all of its residents? _____ Yes _____ No