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State/Territory Name: OH

State Plan Amendment (SPA) #: 18-003

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

Barbara Sears, Director
Ohio Department of Medicaid
P.O. Box 182709
50 West Town Street, Suite 400
Columbus, Ohio 43218

APR 17 2018

RE: Ohio State Plan Amendment (SPA) 18-003

Dear Ms. Sears:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-003. Effective January 1, 2018, this state plan amendment proposes to update payment for services in nursing homes regarding behavioral health, podiatry, and acupuncture.

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 18-003 is approved effective January 1, 2018. 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

3TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER: **18-003**	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 **January 1, 2018**	

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: Section 1902(a)(30)(A) of the Social Security Act Section 1905(a)(4)(A) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY 2018 $0 b. FFY 2019 $0
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT **Attachment 4.19-D, Supplement 1:** Section 001.4, pages 1-2 of 2 Section 001.6, page 1 of 1 Section 001.27 Appendix A, pages 1-61 of 61 Section 001.28 Appendix A, pages 1-51 of 51	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: **Attachment 4.19-D, Supplement 1:** Section 001.4, pages 1-2 of 2 (TN 13-022) Section 001.6, pages 1-2 of 2 (TN 13-022) Section 001.27 Appendix A, pages 1-61 of 61 (TN 17-003) Section 001.28 Appendix A, pages 1-51 of 51 (TN 17-003)

10. SUBJECT OF AMENDMENT: Payment for Services: Nursing Facility Services – Behavioral Health, Podiatry, and Acupuncture

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: **Carolyn Humphrey** **Ohio Department of Medicaid** **P.O. BOX 182709** **Columbus, Ohio 43218**
13. TYPED NAME: **BARBARA R. SEARS**	
14. TITLE: **STATE MEDICAID DIRECTOR**	
15. DATE SUBMITTED: January 25, 2018	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: APR 17 2018
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: JAN 01 2018	20. SIGNATURE OF REGIONAL OFFICIAL: [redacted]
21. TYPED NAME: Kristin Fan	22. TITLE: Director, FMG

23. REMARKS:

Instructions on Back

FORM CMS-179 (07-92)

Relation to Other Services

The nursing facility per diem rate is a comprehensive rate that includes many items and services for which the provider is not paid directly by the Medicaid program. The following items and services are included in the nursing facility per diem rate:

1) Personal hygiene services provided by facility staff or contracted personnel;
2) The purchase and administration of tuberculin tests;
3) Drawing specimens and forwarding specimens to a laboratory;
4) Medical supplies, defined as items with a very limited life expectancy (e.g., atomizers, nebulizers, bed pans, catheters, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits);
5) Needed medical equipment, defined as items that can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility (e.g., hospital beds, wheelchairs other than custom wheelchairs, and intermittent positive-pressure breathing machines). For dates of service on and after January 1, 2014, custom wheelchairs are not included in the nursing facility rate and are covered on a fee for service basis;
6) Emergency oxygen;
7) Over the counter drugs and nutritional supplements;
8) Physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants;
9) Respiratory therapy services, including physician ordered administration of aerosol therapy rendered by a licensed respiratory care professional;
10) Resident transportation other than medically necessary transportation by ambulance or wheelchair van. Medically necessary transportation of residents who do not require an ambulance or wheelchair van is paid through the NF per diem.

The following items and services are not included in the nursing facility per diem rate but are paid directly to the provider by the Medicaid program:

1) Covered dental services provided by licensed dentists;
2) Laboratory and x-ray procedures covered under the Medicaid program;
3) Ventilators, other than services for ventilator dependent individuals as described in Section 001.20.5 of Attachment 4.19-D, Supplement 1;
4) Prostheses and orthoses;
5) Pharmaceuticals, subject to the following conditions:
   a) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient;
   b) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years;
   c) A receipt for drugs delivered to a NF must be signed by the facility representative at the time of delivery; a copy must be maintained by the pharmacy.

6) Behavioral health services;
7) Physician services;
8) Podiatry services;
9) Vision care services;
10) Custom wheelchairs;
11) Non-emergency oxygen;
12) Medically necessary resident transportation by ambulance or wheelchair van.
13) Acupuncture services in accordance with Attachment 3.1-A

Direct Care

Costs Included in Direct Care

Direct care costs are reasonable costs incurred for the following:

1) Registered nurses, licensed practical nurses and nurse aides employed by the facility;
2) Direct care staff, administrative nursing staff, medical directors, respiratory therapists, and other persons holding degrees qualifying them to provide therapy;
3) Purchased nursing services;
4) Quality assurance;
5) Consulting and management fees related to direct care;
6) Allocated direct care home office costs;
7) Habilitation staff, other than habilitation supervisors;
8) Medical supplies, habilitation supplies and universal precaution supplies;
9) Emergency oxygen;
10) Over the counter pharmacy products;
11) Physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, speech therapists, and audiologists;
12) Training and staff development, employee benefits, payroll taxes, workers' compensation premiums, and costs for self-insurance claims for individuals whose wages are included in direct care;
13) Other direct care resources.

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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 18-003 Approval Date APR 17 2018
Supersedes
TN 17-003 Effective Date 1/1/2018

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

ELECTRONIC SUBMISSION OF THE MEDICAID COST REPORT

In accordance with the OAC, all providers are required to use the electronic cost report submission process. Providers 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.

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

APR 17 2018

TN 18-003 Approval Date _____
Supersedes
TN 17-003 Effective Date 1/1/2018

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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.

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Ohio Department of Medicaid
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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.

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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.

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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.

Ohio Department of Medicaid
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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.

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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.

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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

Ohio Department of Medicaid
Medicaid Nursing Facility Cost Report

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 Percentage of Occupancy answer by dividing line 4 by line 3 in Column 2.

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.

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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.

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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 12 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).

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

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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.

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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.

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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

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
WH024	Other Direct Care Salaries - Specify	6220	Schedule B-2, line 12
WH025	Home Office Costs/Direct Care - Salary	6230	Schedule B-2, line 13
WH026	DO NOT USE THIS POSITION CODE		
WH027	In-House Trainer Wages	6500	Schedule B-2, line 25
WH028	Classroom Wages: Nurse Aides	6511	Schedule B-2, line 26
WH029	Clinical Wages: Nurse Aides	6521	Schedule B-2, line 27
WH030	Physical Therapist	6600	Schedule B-2, line 36
WH031	Physical Therapy Assistant	6605	Schedule B-2, line 37
WH032	Occupational Therapist	6610	Schedule B-2, line 38
WH033	Occupational Therapy Assistant	6615	Schedule B-2, line 39
WH034	Speech Therapist	6620	Schedule B-2, line 40
WH035	Audiologist	6630	Schedule B-2, line 41
WH063	EAP Administrator - Therapy	6643	Schedule B-2, line 45
WH064	Self Funded Program Admin.-Therapy	6644	Schedule B-2, line 46
WH065	Staff Development - Therapy	6645	Schedule B-2, line 47
WH036	EAP Administrator - Direct Care	6730	Schedule B-2, line 52
WH037	Self Funded Programs Admin. - Direct Care	6740	Schedule B-2, line 53
WH038	Staff Development - Direct Care	6750	Schedule B-2, line 54
WH039	Dietitian	7000	Schedule C, line 1

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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 75
WH061	Self-Funded Programs Admin. - Ancillary/Support	7840	Schedule C, line 76
WH062	Staff Development - Ancillary/Support	7850	Schedule C, line 77

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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.

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.

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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.

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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.

APR 17 2018

TN 18-003 Approval Date _____
Supersedes
TN 17-003 Effective Date 1/1/2018

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

SUMMARY OF INPATIENT DAYS

Schedule A-1

Provider Name	Medicaid Provider Number		Reporting Period From: Through:

INSTRUCTIONS: All data must be stated on a service date (accrual) basis. For example, January data would include only the applicable days and billings for services rendered during January. 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	Medicaid Patients						Non-Medicaid Patients				Total Inpatient Days (sum cols. 6-11)
		Fee-For-Service Days	MyCare Medicaid Days	Hospital Leave Days (@ 50%)	Therapeutic Leave Days (@ 50%)	Total Medicaid Days (sum cols. 2-5)	Managed Care Days	Private Days	Medicare Days	MyCare Medicare Days	Veterans and Other Days	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
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 15, 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 79, column 3 less Schedule C, lines 18, 24, 51, 52, 53 and 71, column 3)				
9. **Total costs** (total of Schedule B-1, line 5, Schedule B-2, line 56, Schedule C, line 79, 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-56 Col 7		
ANCILLARY/SUPPORT COST CENTER			
3. Ancillary/Support Cost	C line-79 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. B2/56	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.	Consulting and Management Fees - Direct	6210							
12.	Other Direct Care - Specify below	6220							
13.	Home Office Costs/Direct Care **	6230							
14.	**TOTAL Nursing and Habilitation/Rehabilitation** (sum of lines 1 through 13)								
	MEDICAL, HABILITATION, AND UNIVERSAL PRECAUTION SUPPLIES								
15.	Medical Supplies - Medicare Billable	6301							
16.	Medical Supplies - Medicare Non-Billable	6311							
17.	Oxygen - Emergency stand-by	6321							
18.	Habilitation Supplies	6330							
19.	Universal Precaution Supplies	6340							
20.	**TOTAL Medical, Habilitation, and Universal Precaution Supplies** (sum of lines 15 through 19)								
	PURCHASED NURSING SERVICES								
21.	Registered Nurse - Purchased Nursing	6401							
22.	Licensed Practical Nurse - Purchased Nursing	6411							
23.	Nurse Aides - Purchased Nursing	6421							
24.	**TOTAL Purchased Nursing** (sum of lines 21 through 23)								

Line 12 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 12, Columns 1 and 2)		

** Enter home office costs on line 13 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								
25.	In-House Trainer Wages	6500							
26.	Classroom Wages - Nurse Aides	6511							
27.	Clinical Wages - Nurse Aides	6521							
28.	Books and Supplies	6531							
29.	Transportation	6541							
30.	Tuition Payments	6551							
31.	Tuition Reimbursement	6560							
32.	Contractual Payments to Other NFs	6570							
33.	Registration Fees/Application Fees	6580							
34.	Employee Fringe Benefits	6590							
35.	**TOTAL Nurse Aide Training** (sum of lines-25 through 34)								
	DIRECT CARE THERAPIES								
36.	Physical Therapist	6600							
37.	Physical Therapy Assistant	6605							
38.	Occupational Therapist	6610							
39.	Occupational Therapy Assistant	6615							
40.	Speech Therapist	6620							
41.	Audiologist	6630							
42.	Payroll Taxes - Therapy	6640							
43.	Workers' Compensation - Therapy	6650							
44.	Employee Fringe Benefits - Therapy	6660							
45.	EAP Administrator - Therapy	6665							
46.	Self Funded Program Admin. - Therapy	6670							
47.	Staff Development - Therapy	6680							
48.	**TOTAL Direct Care Therapies** (sum of lines -36 through 47)								
	PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT (No Purchased Nursing)								
49.	Payroll Taxes - Direct Care	6700							
50.	Worker's Compensation - Direct Care	6710							
51.	Employee Fringe Benefits - Direct Care	6720							
52.	EAP Administrator - Direct Care	6730							
53.	Self Funded Programs Admin. - Direct Care	6740							
54.	Staff Development - Direct Care	6750							
55.	**TOTAL Payroll Taxes, Fringe Benefits, and Staff Development** (sum of lines-49 through 54)								
56.	**TOTAL REIMBURSABLE DIRECT CARE COST** (sum of lines 14, 20, 24, 35, 48, and 55)								

*** 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
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	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.	Leased Equipment	7740							
71.	**TOTAL Maintenance and Minor Equipment** (sum of lines 66 through 70)								
	PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT								
72.	Payroll Taxes - Ancillary/Support	7800							
73.	Workers' Compensation - Ancillary/Support	7810							
74.	Employee Fringe Benefits - Ancillary/Support	7820							
75.	EAP Administrator - Ancillary/Support	7830							
76.	Self Funded Prog. Admin. - Ancillary/Support	7840							
77.	Staff Development - Ancillary/Support	7850							
78.	**TOTAL Payroll Taxes, Fringe Benefits, and Staff Development** (sum of lines 72 through 77)								
79.	**TOTAL Reimbursable Ancillary/Support Cost** (sum of lines 18, 24, 34, 37, 42, 65, 71, and 78)								

** 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								
80.	Legend Drugs	9705							
81.	Radiology	9710							
82.	Laboratory	9715							
83.	Non-Emergency Oxygen	9720							
84.	Other Non-Reimbursable - Specify below	9725							
85.	Late Fees, Fines or Penalties	9730							
86.	Federal Income Tax	9735							
87.	State Income Tax	9740							
88.	Local Income Tax	9745							
89.	Insurance - Officers' Life	9750							
90.	Promotional Advertising and Marketing	9755							
91.	Contributions and Donations	9760							
92.	Bad Debt	9765							
93.	Parenteral Nutrition Therapy	9770							
94.	Franchise Permit Fees	9776							
95.	**TOTAL Non-Reimbursable Expenses** (sum of lines 80 through 94)								
96.	**TOTAL Ancillary/Support Cost Reimbursable and Non-Reimbursable** (sum of lines-79 and 95)								

Line 84 Other Non-Reimbursable

Account Title	Salary Column 1	Other Column 2
TOTAL (must tie to line 84, 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.

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 22 through 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 (1)	Social Security Number (2)	Facility Name (3)	Number of Beds (4)	Medicaid Provider Number (5)	Paid Weekly Hours * (6)	Paid Weekly % (7)	Amount of Compensation (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.

APR 17 2018

TN 18-003 Approval Date _____
Supersedes
TN 17-003 Effective Date 1/1/2018

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.

APR 17 2018

TN 18-003 Approval Date _____
Supersedes
TN 17-003 Effective Date 1/1/2018

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 5165.01 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.

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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 Acct. No.	BALANCE PER BOOKS	
CURRENT ASSETS		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

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)					

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)	

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)				

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						

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Supersedes
TN 17-003 Effective Date 1/1/2018

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.	Consulting and Management Fees-Direct	6210						
12.	Other Direct Care - Specify below	6220						
13.	Home Office Costs/Direct Care (salary)	6230						
14.	**TOTAL Nursing and Habilitation / Rehabilitation** (sum of lines 1 through 13)							
	NURSE AIDE TRAINING							
15.	In-House Trainer Wages	6500						
16.	Classroom Wages: Nurse Aides	6511						
17.	Clinical Wages: Nurse Aides	6521						
18.	**TOTAL Nurse Aide Training** (sum of lines 15 through 17)							
	DIRECT CARE THERAPIES							
19.	Physical Therapist	6600						
20.	Physical Therapy Assistant	6605						
21.	Occupational Therapist	6610						
22.	Occupational Therapy Assistant	6615						
23.	Speech Therapist	6620						
24.	Audiologist	6630						
25.	EAP Administrator - Therapy	6665						
26.	Self-Funded Program Admin. - Therapy	6670						
27.	Staff Development - Therapy	6680						
28.	**TOTAL Direct Care Therapies** (sum of lines 19 through 27)							
	PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - DIRECT CARE							
29.	EAP Administrator - Direct Care	6730						
30.	Self-funded Programs Administrator - Direct Care	6740						
31.	Staff Development - Direct Care	6750						
32.	**TOTAL Payroll Tax, Fringe Benefits, and Staff Development** (sum of lines 29 through 31)							
33.	**TOTAL Page 1** (sum of lines 14, 18, 28 and 32)							

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							
34.	Dietitian	7000						
35	Food Service Supervisor	7005						
36.	Dietary Personnel	7015						
37.	EAP Administrator - Dietary	7075						
38.	Self Funded Programs Admin - Dietary	7080						
39.	Staff Development - Dietary	7090						
40	**TOTAL Dietary** (sum of lines 34 through 39)							
	HABILITATION AND PHARMACEUTICAL							
41.	Medical/Habilitation Records	7105						
42.	Pharmaceutical Consultant	7110						
43.	**TOTAL Habilitation and Pharmaceutical** (sum of lines-41 and 42)							
	ACTIVITIES, HABILITATION, AND SOCIAL SERVICES							
44.	Activity Director	7201						
45.	Activity Staff	7211						
46.	Recreational therapist	7221						
47.	Psychologist	7231						
48.	Psychology Assistant	7241						
49.	Social Work/Counseling	7251						
50.	Social Services/Pastoral Care	7261						
51.	Habilitation Supervisor	7271						
52.	Program Director	7281						
53.	**TOTAL Activities, Habilitation, and Social Services** (sum of lines 44 through 52)							
	UTILITIES							
54.	Water and Sewage (salary only)	7511						
	ADMINISTRATIVE AND GENERAL SERVICES							
55.	Administrator	7600						
56.	Other Administrative Personnel	7605						
57.	Security Services - (salary only)	7625						
58.	Resident Transportation	7631						
59.	Laundry/Housekeeping Supervisor	7635						
60.	Housekeeping	7640						
61.	Laundry and Linen	7645						
62.	Accounting	7655						
63.	Data Services (salary only)	7675						
64.	Other Ancillary/Support (salary only)	7690						
65.	Home Office Ancillary Care Salary	7695						
66.	**TOTAL Administrative and General Services** (sum of lines 55 through 65)							
	MAINTENANCE PERSONNEL							
67.	Plant Operations Maintenance Supervisor	7700						
68.	Plant Operations and Maintenance	7710						
69.	**TOTAL Maintenance Personnel** (sum of lines 67 and 68)							
	PAYROLL TAXES, FRINGE BENEFITS AND STAFF DEVELOPMENT - ANCILLARY/SUPPORT							
70.	EAP Administrator - Ancillary/Support	7830						
71.	Self Funded Prog. Admin.- Ancillary/Support	7840						
72.	Staff Development - Ancillary/Support	7850						
73.	**TOTAL Payroll Taxes, Fringe Benefits, and Staff Development - Ancillary/Support** (sum of 70 thru 72)							
74.	**TOTAL Page 2** (sum of lines 40, 43, 53, 54, 66, 69, and 73)							
75.	**TOTAL ATTACHMENT 6 Pages 1 and 2** (sum of lines 33 and 74)							

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)							

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Employee Retention Rate

Attachment 8

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%) _____

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

CHART OF ACCOUNTS

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TABLE 1

BALANCE SHEET ACCOUNTS – ASSETS

CURRENT ASSETS

1001 Petty Cash

1010 Cash in Bank

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

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

1030 Accounts Receivable

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

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

1040 Allowance for Uncollectible Accounts Receivable

This account represents the estimated amount of uncollectible receivables.

CHART OF ACCOUNTS

1050 Notes Receivable

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

1060 Allowance for Uncollectible Notes Receivable

This account represents the estimated amount of uncollectible notes receivables.

1070 Other Receivables

1070.1 Employees
1070.2 Sundry

1080 Cost Settlements

1080.1 Medicare
1080.2 Medicaid

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

1090 Inventories

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

These accounts represent the cost of unused nursing facility supplies.

CHART OF ACCOUNTS

1100 Prepaid Expenses

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

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

1110 Short – Term Investments

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

1120 Special Expenses

1120.1 Telephone systems
1120.2 Prior authorized medical equipment

Unamortized cost of telephone systems and prior authorized medical equipment. Amortized cost of telephone systems acquired before 12/1/92, if the costs were reported as administrative and general on the facility's cost report for the period ending 12/31/92, should be reported in account 7620.

CHART OF ACCOUNTS

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1200 Property, Plant and Equipment

Nursing facilities that did not change operator on or after 7/01/93 need only use group (A). Nursing facilities that did change operator on or after 7/01/93 use groups (A) and (B).

(A)
- 1200.1 Land
- 1200.2 Land improvements
- 1200.3 Building and building improvements
- 1200.4 Equipment
- 1200.5 Transportation equipment
- 1200.6 Leasehold improvements
- 1200.7 Financing cost – cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) NFs that changed operator on or after 7/01/93 use this group to report assets acquired through a change of operator on or after 7/01/93.

- 1200.8 Land acquired on or after 7/01/93 through a change of operator
- 1200.9 Building and building improvements acquired on or after 7/01/93 through a change of operator
- 1200.10 Equipment acquired on or after 7/01/93 through a change of operator

(C) (Assets under capital lease)

- 1200.18 Assets under capital lease – prior to 5/27/92
- 1200.19 Assets under capital lease – on or after 5/27/92

CHART OF ACCOUNTS

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1250 Accumulated Depreciation and Amortization – Prop., Plant and Equip.

Nursing facilities that did not change operator on or after 7/01/93 need only use group (A). Nursing facilities that did change operator on or after 7/01/93 use groups (A) and (B).

(A) 1250.1 Land improvements
1250.2 Building and building improvements
1250.3 Equipment
1250.4 Transportation equipment
1250.5 Leasehold improvements
1250.6 Financing cost – cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) NFs that changed operator on or after 7/01/93 use this group to report assets acquired through a change of operator on or after 7/01/93.

1250.7 Building and building improvements acquired on or after 7/01/93 through a change of operator
1250.8 Equipment acquired on or after 7/01/93 through a change of operator

(C) (Assets under capital lease)

1250.18 Assets under capital lease – prior to 5/27/92
1250.19 Assets under capital lease – on or after 5/27/92

1300 Nonextensive Renovations
As defined in the Ohio Revised Code (ORC).

(A) 1300.1 Building and building improvements
1300.2 Equipment
1300.3 Leasehold improvements
1300.4 Financing Cost – cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) (Assets under capital lease)

1300.9 Assets under capital lease – prior to 5/27/92
1300.10 Assets under capital lease – on or after 5/27/92

1350 Accumulated Depreciation and Amortization – Nonextensive Renovations

(A) 1350.1 Building and building improvements

CHART OF ACCOUNTS

1350.2 Equipment
1350.3 Leasehold improvements
1350.4 Financing cost – cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc.

(B) (Assets under capital lease)

1350.9 Assets under capital lease – prior to 5/27/92
1350.10 Assets under capital lease – on or after 5/27/92

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OTHER ASSETS

1400 Non-Current Investments

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

1410 Deposits

1410.1	Workers' compensation
1410.2	Leases
1410.3	Other

1420 Due From Owners/Officers

1420.1	Officers
1420.2	Owners

1430 Deferred Charges and Other Assets

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

1440 Notes Receivable – Long Term

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

CHART OF ACCOUNTS

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TABLE 2

BALANCE SHEET ACCOUNTS – LIABILITIES

CURRENT LIABILITIES

2010 Accounts Payable

2010.1 Trade
2010.2 Resident deposits – private
2010.3 Resident funds

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

2020 Cost Settlements

2020.1 Medicare
2020.2 Medicaid

These accounts represent amounts due to Medicare or Medicaid from current or prior unsettled cost reporting periods.

2030 Notes Payable

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

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

CHART OF ACCOUNTS

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2040 Current Portion of Long Term Debt

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

2050 Accrued Compensation

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

2060 Payroll Related Withholding and Liabilities

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

CHART OF ACCOUNTS

2080 Taxes Payable

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

2090 Other Liabilities

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

CHART OF ACCOUNTS

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LONG TERM LIABILITIES

2410 Long Term Debt

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

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

2420 Related Party Loans
Interest allowable under Medicare guidelines.

2430 Related Party Loans
Interest non-allowable under Medicare guidelines.

2440 Non-Interest Bearing Loans from Owners
See the Centers for Medicare and Medicaid Services (CMS) Publication 15-1, section 1210

2450 Deferred Liabilities

- 2450.1 Revenue
- 2450.2 Federal income taxes
- 2450.3 State income taxes
- 2450.4 Local income taxes

CHART OF ACCOUNTS

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TABLE 3

BALANCE SHEET ACCOUNT-CAPITAL

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

3000 Capital

CHART OF ACCOUNTS

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TABLE 4

REVENUE ACCOUNTS

ROUTINE SERVICE REVENUES

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

ANCILLARY SERVICE REVENUES

5020 Physical Therapy
5030 Occupational Therapy
5040 Speech Therapy
5050 Audiology Therapy
5060 Respiratory Therapy
5070 Medical Supplies – Medicare
Items that are billable to Medicare regardless of payer type.

- 5070.1 Medicare B – Medicaid
- 5070.2 Medicare B – Other
- 5070.3 Private
- 5070.4 Medicare A
- 5070.5 Veterans
- 5070.6 Other
- 5070.7 Medicaid

5080 Medical Supplies - Routine
Medicaid allowable supplies that are not billable to Medicare regardless of payer type.

5085 Habilitation Supplies

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5090 Medical Minor Equipment – Medicare
Items that are billable to Medicare regardless of payer type.

- 5090.1 Medicare B – Medicaid
- 5090.2 Medicare B – Other
- 5090.3 Private
- 5090.4 Medicare A
- 5090.5 Veterans
- 5090.6 Other
- 5090.7 Medicaid

5100 Medical Minor Equipment – Routine
Medicaid allowable equipment that are not billable to Medicare regardless of payer type.

5110 Enteral Nutrition Therapy – Medicare
Items that are billable to Medicare regardless of payer type.

- 5110.1 Medicare B – Medicaid
- 5110.2 Medicare B – Other
- 5110.3 Private
- 5110.4 Medicare A
- 5110.5 Veterans
- 5110.6 Other
- 5110.7 Medicaid

5120 Enteral Nutrition Therapy – Routine
Medicaid allowable enterals that are not billable to Medicare regardless of payer type.

5140 Incontinence Supply
5150 Personal Care
5160 Laundry Service – Routine

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OTHER SERVICE REVENUES

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

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

NON-OPERATING REVENUES

5510 Management Services
5520 Cash Discounts
5530 Rebates and Refunds
5540 Gift Shop
5550 Vending Machine Revenues
5555 Vending Machine Commissions
5560 Rental-Space
5570 Rental-Equipment
5580 Rental-Other
5590 Interest Income – Working Capital
5600 Interest Income – Restricted Funds
5610 Interest Income – Funded Depreciation
5620 Interest Income – Related Party Revenue
5625 Interest Income – Contributions
5630 Endowments
5640 Gain/Loss on Disposal of Assets
5650 Gain/Loss on Sale of Investments
5660 Nurse Aide Training Program Revenue
5670 Unrestricted Contributions

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DEDUCTIONS FROM REVENUES

5710 Contractual Allowance – Medicare
5720 Contractual Allowance – Medicaid

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

5740 Charity Allowance

CHART OF ACCOUNTS

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TABLE 5

TAX COST

TAXES

6060 Real Estate Taxes
Real property tax expense incurred by the provider.

6070 Personal Property Taxes
Personal property tax expense incurred by the provider.

6080 Franchise Tax
Allowable portion of franchise tax as defined in section 2122.4 of CMS Publication 15-1.

6085 Commercial Activity Tax (CAT)
Annual business privilege tax; begun July 1, 2005.

CHART OF ACCOUNTS

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TABLE 6

DIRECT CARE COSTS

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

NURSING AND HABILITATION/REHABILITATION

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

6100.1 Medical director – salary
6100.2 Medical director – contract

6105 Director of Nursing
A full time registered nurse who has, in writing, administrative authority, responsibility, and accountability for the functions, activities and training of the nursing services staff, and serves only one nursing facility in this capacity. (NFs that receive a waiver from the state of Ohio are not required to have a full-time director of nursing.)

6105.1 Director of nursing – salary
6105.2 Director of nursing – contract

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

6110.1 RN charge nurse – salary
6110.2 RN charge nurse – contract

CHART OF ACCOUNTS

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

6115.1 LPN charge nurse – salary
6115.2 LPN charge nurse – contract

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

6120.1 Registered nurse – salary
6120.2 Registered nurse – contract

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

6125.1 Licensed practical nurse – salary
6125.2 Licensed practical nurse – contract

6130 Nurse Aides
Salary of individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to, bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. This account does not include nurse aides from a nursing pool agency (purchased nursing). (Excludes housekeeping and laundry duties.)

CHART OF ACCOUNTS

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

6170.1 Habilitation staff – salary
6170.2 Habilitation staff – contract

6185 Respiratory Therapist
A professional licensed under state law to render respiratory care.

6185.1 Respiratory therapist – salary
6185.2 Respiratory therapist – contract

6205 Quality Assurance
Individuals providing the quality assurance functions in the facility, as overseen by the committee established under 42 CFR, Section 483.75 (O). (Supplies are included in program supplies.) This account includes costs previously reported as utilization review personnel.

6205.1 Quality assurance – salary
6205.2 Quality assurance – contract

6210 Consulting and Management Fees
Direct care consulting fees that are paid to a non-related entity pursuant to the OAC, are necessary pursuant to CMS Publication 15-1, section 2135, and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.

CHART OF ACCOUNTS

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

6220.1 Other direct care – salary
6220.2 Other direct care – contract

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

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

CHART OF ACCOUNTS

MEDICAL SUPPLIES

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

For those facilities participating in Medicaid and not in Medicare, all medical supplies are to be classified in account 6311. For those facilities participating in both the Medicare and Medicaid programs, medical supplies must be categorized and classified as follows:

6301 Medical Supplies Billable to Medicare
Medical supplies for facilities participating in Medicare that are billable to Medicare regardless of payer type.

6311 Medical Supplies Non-Billable to Medicare
Medical supplies for facilities not participating in Medicare, as well as medical supplies for facilities that are not billable to Medicare regardless of payer type.

6321 Oxygen – Emergency stand-by only

6330 Habilitation Supplies
Supplies used to provide services measured by the current version of the minimum data set (MDS), which assist the resident to cope with daily living, the aging process, and performance of tasks normally performed at his/her chronological stage of development. Does not include cost of meals for out-of-facility functions.

6340 Universal Precaution Supplies
Supplies required for the protection of residents and facility staff while performing procedures which involve the handling of bodily fluids. Supplies include masks, gloves, gowns, goggles, boots, and eye wash. (Excludes trash bags and paper towels.)

CHART OF ACCOUNTS

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PURCHASED NURSING SERVICES

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

6401 Registered Nurse Purchased Nursing
Registered nurses providing direct nursing care to residents.

6411 Licensed Practical Nurse Purchased Nursing
Licensed practical nurses providing direct nursing care to residents.

6421 Nurse Aides Purchased Nursing
Individuals, other than licensed health professionals, directly providing nursing or nursing-related services to residents in a facility and non-technical personnel providing support for direct nursing care to residents. Their responsibilities may include, but are not limited to, bathing, dressing, and personal hygiene of the residents, as well as activities of daily living. (Excludes housekeeping and laundry duties.)

CHART OF ACCOUNTS

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NURSE AIDE TRAINING

6500 In-House Trainer Wages
This account includes, and is limited to, train the trainer salary or wages while attending a state approved program, guest speaker fees, and salaries and wage expense for the primary instructor and program coordinator providing facility-based nurse aide training programs in order to comply with the ORC.

6511 Classroom Wages: Nurse Aides
This account is limited to wages paid to nurse aides during the classroom portion of the state approved training and competency evaluation programs, wages paid for continuing education pursuant to the ORC, and wages paid during the state approved competency test including travel time. Include only those wages paid for your own facility staff.

6521 Clinical Wages: Nurse Aides
This account is limited to wages paid to nurse aides during the clinical portion of the state approved training and competency evaluation programs and wages paid for continuing education pursuant to the ORC. Include only those wages paid for your own facility staff.

6531 Books and Supplies
This account is limited to books and supplies expense incurred by the facility for nurse aide training, i.e., textbooks and reference material used for class preparation. This account does not include costs that may be used in more than one cost center, i.e., office supplies, expense of operating a copier, linens, computers, etc. (Mannequins will only be considered in their entirety and are subject to the capitalization policy stated in the capital cost center, paragraph A.)

CHART OF ACCOUNTS

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6541 Transportation
This account is limited to the mileage allowance paid to nurse aides from your facility to attend either a classroom or clinical training session at a state approved nurse aide training program and/or mileage allowance paid to nurse aides to attend state approved competency tests, e.g., using the individual's own vehicle. This account does not include expense incurred for the use of a facility's own vehicle.

6551 Tuition Payments
This account is limited to tuition payments to other entities that provide state approved nurse aide training for your nurse aides in order to comply with the ORC, excluding payments to other nursing facilities.

6560 Tuition Reimbursement
This account is limited to the reimbursement of costs incurred by the facility to reimburse an individual who is not employed, or does not have an offer to be employed, as a nurse aide but becomes employed by, or received an offer for employment from, the facility not later than twelve months after completing a nurse aide training and competency evaluation program. Reimbursement to the nurse aide shall be made on a pro-rata basis during the period in which the individual is employed as a nurse aide.

6570 Contractual Payments to Other Nursing Facilities
The account is limited to payments to other nursing facilities that provide state approved nurse aide training for your nurse aides in order to comply with the ORC.

6580 Registration Fees and Application Fees
This account is limited to all registration fees and application fees necessary to comply with the ORC, i.e., train the trainer fees in order to comply with the ORC and state approved competency exam fees for nurse aides.

6590 Employee Fringe Benefits
Nurse aide training (series # 6500) – This account is limited to fringe benefits for employees providing and/or attending state approved nurse aide training/testing programs pursuant to the ORC. Includes self insurance funds. (This account excludes vacation and sick pay salary.)

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DIRECT CARE THERAPIES

6600 Physical Therapist
A qualified professional licensed under Ohio law as physical therapist.
6600.1 Physical therapist – salary
6600.2 Physical therapist – contract

6605 Physical Therapy Assistant
An individual licensed under Ohio law as a physical therapy assistant.
6605.1 Physical therapy assistant – salary
6605.2 Physical therapy assistant – contract

6610 Occupational Therapist
A qualified professional licensed under Ohio law as an occupational therapist.
6610.1 Occupational therapist – salary
6610.2 Occupational therapist – contract

6615 Occupational Therapy Assistant
An individual licensed under Ohio law as an occupational therapy assistant.
6615.1 Occupational therapy assistant – salary
6615.2 Occupational therapy assistant – contract

6620 Speech Therapist
A qualified professional licensed under Ohio law as a speech therapist.
6620.1 Speech therapist – salary
6620.2 Speech therapist – contract

6630 Audiologist
A qualified professional licensed under Ohio law as an audiologist.
6630.1 Audiologist – salary
6630.2 Audiologist – contract

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DIRECT CARE THERAPIES PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

6640 Payroll Taxes – Therapy

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

6650 Workers' Compensation – Therapy

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

6660 Employee Fringe Benefits – Therapy

Direct care therapies fringe benefits such as: medical and life insurance premiums or self insurance funds; employee stock option program; pension and profit sharing; personal use of autos; employee inoculations, employee assistance program, and employee meals, as defined in CMS Publication 15-1, section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. This account does not include benefits for nursing facility personnel in account 6590, employee fringe benefits for nurse aide training. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6665 Employee Assistance Program Administrator – Therapy

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

6665.1 EAP administrator therapy – salary
6665.2 EAP administrator therapy – contract

CHART OF ACCOUNTS

6670 Self Funded Program Administrator – Therapy
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to direct care therapies.)

6670.1 Self-funded administrator therapy – salary
6670.2 Self-funded administrator therapy – contract

6680 Staff Development – Therapy
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with direct care therapies personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

6680.1 Staff development therapy – salary
6680.2 Staff development therapy – other

DIRECT PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

This series represents payroll taxes, workers' compensation, fringe benefits, EAP administrator, self funded programs administrator and staff development. These accounts should not be used to report payroll taxes, workers compensation, and fringe benefits for Direct Care Therapies, which should be reported in accounts 6640 through 6645.2.

6700 Payroll Taxes
Direct care payroll related expenses incurred such as: employer's portion of FICA taxes or Ohio Public Employees Retirement System (OPERS); state unemployment taxes or self insurance funds for unemployment compensation as stated in CMS Publication 15-1, section 2122.6; and federal unemployment taxes (excludes purchased nursing).

6710 Workers' Compensation
Direct care premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in CMS Publication 15-1, section 2122.6 (excludes purchased nursing).

CHART OF ACCOUNTS

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6720 Employee Fringe Benefits
Direct care fringe benefits such as: medical and life insurance premiums or self insurance funds; employee stock option program; pension and profit sharing; personal use of autos; employee inoculations, employee assistance program, and employee meals, as defined in CMS Publication 15-1, section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. This account does not include benefits for nursing facility personnel in account 6590, employee fringe benefits for nurse aide training. (This account excludes purchased nursing as well as vacation and sick pay salary.)

6730 Employee Assistance Program Administrator – Direct Care
An individual who performs the duties of the employee assistance program administrator for direct care personnel.

6730.1 EAP administrator direct care – salary
6730.2 EAP administrator direct care – contract

6740 Self Funded Programs Administrator – Direct Care
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to direct care.)

6740.1 Self-funded administrator direct care – salary
6740.2 Self-funded administrator direct care – contract

6750 Staff Development – Direct Care
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with direct care personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

6750.1 Staff development direct care – salary
6750.2 Staff development direct care – contract

CHART OF ACCOUNTS

TABLE 7

ANCILLARY/SUPPORT COSTS

Ancillary/Support costs includes costs other than direct care costs, tax costs, or capital costs.

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

7000.1 Dietitian – salary
7000.2 Dietitian – contract

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

7005.1 Food service supervisor – salary
7005.2 Food service supervisor – contract

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

7015.1 Dietary personnel – salary
7015.2 Dietary personnel – contract

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

7030 Dietary Minor Equipment
Dietary equipment that does not meet the facility's capitalization criteria specified in the Ohio Administrative Code (OAC).

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7035 Dietary Maintenance and Repair
Maintenance supplies, purchased services and maintenance contracts for the dietary department.

7040 Food In-Facility
Food required to prepare meals in the facility.

7045 Employee Meals
Employee meals that do not qualify under CMS Publication 15-1, section 2144 "Fringe Benefits".

7050 Contract Meals and Contract Meals Personnel
Expenses associated with contracting for the food service function in the facility. (Includes food services delivered to the facility from an outside vendor.)

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

7055 Enterals: Medicare Billable
Enteral nutritional therapy and additive (food facilitators), whether administered orally or tube fed, for facilities participating in Medicare which are billable to Medicare regardless of payer type.

7056 Enterals: Medicare Non-Billable
Enteral nutritional therapy and additives (food facilitators), whether administered orally or tube fed, for facilities not participating in Medicare, as well as enterals for facilities which are not billable to Medicare regardless of payer type.

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DIETARY PAYROLL TAXES, FRINGE BENEFITS, STAFF DEVELOPMENT

7060 Payroll Taxes – Dietary
(series #7000) Payroll-related expenses incurred, which are employer's portion of FICA taxes or Ohio public employees' retirement system (OPERS), state unemployment taxes or self insurance funds for unemployment compensation as stated in CMS Publication 15-1, section 2122.6, and federal unemployment taxes.

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

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

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

7075.1 EAP administrator dietary – salary
7075.2 EAP administrator dietary – contract

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

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

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

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

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MEDICAL/HABILITATION, PHARMACEUTICAL AND INCONTINENCE SUPPLIES

7105 Medical/Habilitation Records
Personnel responsible for maintaining clinical records on each resident in accordance with accepted professional standards and practices.

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

7110 Pharmaceutical Consultant
The services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility as stated in 42 CFR, Section 483.60(h).

7110.1 Pharmaceutical consultant – salary
7110.2 Pharmaceutical consultant – contract

7115 Incontinence Supplies
Reusable and disposable incontinence supplies (except catheters). Supplies include cloth or disposable diapers, under-pads, plastic pants, and the cost of diaper service of such items.

7120 Personal Care
Supplies required for maintenance of routine personal hygiene of the body, hair, and nails of the hands and feet. Includes body lotion, body powder, toothbrush and toothpaste, disposable razors and shaving supplies, hair cuts, shampoo, and routine hair care supplies provided by facility. (Excludes contract beautician who performs non-routine services.)

7125 Program Supplies
Supplies used to provide activity, social services and religious programs available to all residents. Does not include cost of meals for out of facility functions.

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ACTIVITY AND HABILITATION/REHABILITATION

7201 Activity Director
A professional, as required by the Code of Federal Regulations, who oversees and is responsible for the activity program.

7201.1 Activity director – salary
7201.2 Activity director – contract

7211 Activity Staff
Personnel providing services related to the activity program.

7211.1 Activity personnel – salary
7211.2 Activity personnel – contract

7221 Recreational Therapist
A professional, as required by the Code of Federal Regulations, who oversees and is responsible for the recreational program.

7221.1 Recreational therapist – salary
7221.2 Recreational therapist – contract

7231 Psychologist
A professional licensed under state law to practice psychology.

7231.1 Psychologist – salary
7231.2 Psychologist – contract

7241 Psychology Assistant
An individual trained in psychology to assist the psychologist.

7241.1 Psychology assistant – salary
7241.2 Psychology assistant – contract

7251 Social Work/Counseling
A professional licensed under state law to practice social work or counseling.

7251.1 Social work/counseling – salary
7251.2 Social work/counseling – contract

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7261 Social Services/Pastoral Care
Personnel providing social services and/or pastoral services.

7261.1 Social services/pastoral care – salary
7261.2 Social services/pastoral care – contract

7271 Habilitation Supervisor
Supervisor responsible for the delivery of services to residents with mental retardation or developmental disabilities in a nursing facility to allow them to attain or maintain their highest practicable level of functioning.

7271.1 Habilitation supervisor – salary
7271.2 Habilitation supervisor – contract

7281 Program Director
An individual who carries out and monitors the various professional interventions in accordance with the stated goals and objectives of every individual program plan. Implements the active treatment or specialized service program defined by each resident's individual program plan. Works directly with residents and with paraprofessional, nonprofessional, and other professional program staff who work with residents.

7281.1 Program director – salary
7281.2 Program director – contract

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MEDICAL MINOR EQUIPMENT

Medical minor equipment limited to enteral pumps, bed cradles, headgear, heat cradles, hernial appliances, splints, traction equipment, hypothermia or hyperthermia blankets, egg crate mattresses, and gel cushions. Medical equipment that does not qualify for the facility asset capitalization policy and is not included in this group should be reported in minor equipment, account 7730.

For those facilities participating in Medicaid and not in Medicare, all medical minor equipment should be classified in account 7302. For those facilities participating in both the Medicare and Medicaid programs, medical minor equipment must be categorized and classified as follows:

7301 Medical Minor Equipment Billable to Medicare

Medical minor equipment for facilities participating in Medicare that are billable to Medicare regardless of payer type.

7302 Medical Minor Equipment Non-Billable to Medicare

Medical minor equipment for facilities not participating in Medicare, as well as medical minor equipment for facilities that are not billable to Medicare regardless of payer type.

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UTILITY EXPENSES

7501 Heat, Light, Power
Services provided to furnish heat, light and power. (This account does not include costs associated with on-site salaries or maintenance of heat, light, power.)

7511 Water and Sewage
Services provided to furnish water and sewage treatment for facilities without on-site water and sewage plants. For facilities which have on-site water and sewer plants, this account includes the costs associated with the maintenance and repair of such operations, including the EPA test. The supplies are limited to expendable water and sewage treatment and water softener supplies that are used on the water and sewer system. Payroll taxes and fringe benefits should be reported under accounts 7800 and 7820, respectively.

7511.1 Water and sewage – salary
7511.2 Water and sewage – other

7521 Trash and Refuse Removal
Services provided to furnish trash and refuse removal, including grease trap removal fees. (This excludes housekeeping items such as trash bags.)

7531 Hazardous Medical Waste Collection
Contract services provided to furnish hazardous waste collection bags, containers and removal service.

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ADMINISTRATIVE AND GENERAL SERVICES

7600 Administrator
Expenses incurred by a facility for an individual(s) who functions as the administrator licensed by the state of Ohio and who is responsible for the direction, supervision and coordination of facility functions.

7600.1 Administrator – salary
7600.2 Administrator – contract

7605 Other Administrative Personnel
Administrator in training, assistant administrator, business manager, purchasing agent, human resources, receptionist, secretarial and clerical staff.

7605.1 Other administrative – salary
7605.2 Other administrative – contract

7610 Consulting and Management Fees
Ancillary/Support consulting fees that are paid to a non-related entity pursuant to the OAC, are necessary pursuant to CMS Publication 15-1, Section 2135, and that do not duplicate services or functions provided by the facility's staff or other provider contractual services.

7615 Office and Administrative Supplies
Supplies such as copier supplies, printing, postage, office supplies, nursing/habilitation and medical records forms, and data service supplies.

7620 Communications
Service charges for telephone services.

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7625 Security Services
Salaries, purchased services, or supplies to protect property and residents.

7625.1 Security services – salary
7625.2 Security services – other

7630 Travel and Entertainment
Expenses such as mileage allowance, gas, and oil for vehicles owned or leased by the facility, meals, lodging, and commercial transportation expense incurred in the normal course of business. Includes all purchased commercial transportation services for ambulatory/non-ambulatory residents. Excludes transportation cost that is directly reimbursed by Medicaid to the transportation provider as set forth in the OAC.

7631 Resident Transportation
Report all resident transportation in this account.

7631.1 Resident transportation – salary
7631.2 Resident transportation – other

7635 Laundry/Housekeeping Supervisor
An individual who supervises the laundry/housekeeping functions and/or personnel.

7635.1 Laundry/Housekeeping supervisor – salary
7635.2 Laundry/Housekeeping supervisor – contract

7640 Housekeeping
Housekeeping services, including supplies, wages, and purchased services. This includes trash bags and paper towels.

7640.1 Housekeeping – salary
7640.2 Housekeeping – other

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7645 Laundry and Linen
Laundry services, including supplies, wages, and purchased services, as well as linens for all areas. Excluding incontinence supplies specified in account 7115.

7645.1 Laundry/linen – salary
7645.2 Laundry/linen – other

7650 Legal Services
Legal services except as excluded in the OAC.

7655 Accounting
Accounting, Bookkeeping Fees and Salaries.

7655.1 Accounting – salary
7655.2 Accounting – contract

7660 Dues, Subscriptions and Licenses
Expense of dues, subscriptions and licenses incurred by facility.

7665 Interest – Other
Expense of short term credit and working capital interest incurred. (This account does not include late fees, fines or penalties.)

7670 Insurance
Expense of insurance such as general business, liability, malpractice, vehicle, and property insurance.

7675 Data Services
Data services personnel and purchased services.

7675.1 Data services – salary
7675.2 Data services – contract

7680 Help Wanted/Informational Advertising
Help wanted ads, yellow pages, and other advertising media that are informational as opposed to promotional in nature as stated in CMS Publication 15-1, section 2136.1.

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7685 Amortization of Start-Up Costs
Amortization of costs included in account 1430.5, not otherwise allocated to other cost centers, in accordance with CMS Publication 15-1, section 2132, which were incurred by a facility.

7686 Amortization of Organizational Costs
Amortization of cost included in account 1430.3, as described in CMS Publication 15-1, section 2134.

7690 Other Ancillary/Support Administrative Services – Specify below
Ancillary/Support administrative services not previously listed.

7690.1 Other Ancillary/Support – salary
7690.2 Other Ancillary/Support – contract

HOME OFFICE COSTS

7695 Home Office Costs/Ancillary/Support
Ancillary/Support expenses of a separate division or entity that owns, leases or manages more than one facility (home office). These costs must be related to administrative and management services allocated to the facility in accordance with CMS Publication 15-1, section 2150 through 2150.3, "Home Office Costs."

7695.1 Home office/Ancillary/Support – salary
7695.2 Home office/Ancillary/Support – other

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MAINTENANCE AND MINOR EQUIPMENT

7700 Plant Operations and Maintenance Supervisor
An individual who supervises the plant operations and maintenance procedures and/or maintenance personnel.

7770.1 Operations/maintenance supervisor – salary
7770.2 Operations/maintenance supervisor – contract

7710 Plant Operations and Maintenance
Salaries for all maintenance personnel employed by the facility.

7720 Repair and Maintenance
Supplies, purchased services and maintenance contracts for all departments. (Excludes dietary maintenance account 7035 and on-site water and sewage account 7511.)

7730 Minor Equipment
Equipment that does not meet the facility's capitalization criteria specified under the OAC. The general characteristics are: comparatively small in size and unit cost; subject to inventory control; fairly large quantity is used; and generally, a useful life of approximately three years or less. (Exclude account 7030 – dietary minor equipment, and items listed in accounts 7301 and 7302 – medical minor equipment.)

EQUIPMENT ACQUIRED BY OPERATING LEASE

7740 Leased Equipment
This account includes the cost of equipment, including vehicles, acquired by operating lease executed before December 1, 1992, if the costs are reported as administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992. (All leases effective after 12/01/92, should be reported in account 8065 for assets acquired prior to 7/01/93).

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ANCILLARY/SUPPORT PAYROLL TAXES, FRINGE BENEFITS, AND STAFF DEVELOPMENT

7800 Payroll Taxes
Ancillary/Support payroll-related expenses incurred, such as: employer's portion of FICA taxes or Ohio public employees retirement system (OPERS); state unemployment taxes or self insurance funds for unemployment compensation according to CMS Publication 15-1, section 2122.6; and federal unemployment taxes.

7810 Workers' Compensation
Ancillary/Support premiums incurred by the facility for state of Ohio Bureau of Workers' Compensation or self insurance program as stated in CMS Publication 15-1, section 2122.6.

7820 Employee Fringe Benefits
Ancillary/Support fringe benefits such as medical and life insurance premiums or self insurance funds, employee stock option program, pension and profit sharing, personal use of autos, employee inoculations, employee assistance program, and employee meals, as defined in CMS Publication 15-1, section 2144. If fringe benefits are discriminatory to owners and related parties, they are considered part of compensation. (This account excludes vacation and sick pay salary.)

7830 Employee Assistance Program Administrator – Ancillary/Support
An individual who performs the duties of the employee assistance program administrator for Ancillary/Support personnel.

7830.1 EAP administrator Ancillary/Support – salary
7830.2 EAP administrator Ancillary/Support – contract

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7840 Self-Funded Programs Administrator – Ancillary/Support
An individual who performs the administrative functions of the self insured programs. (Report only the portion related to Ancillary/Support.)

7840.1 Self-funded admin. Ancillary/Support – salary
7840.2 Self-funded admin. Ancillary/Support – contract

7850 Staff Development – Ancillary/Support
Continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Includes travel costs for individual's own vehicle, associated with Ancillary/Support personnel for attending training. This account does not include expenses incurred for the use of a facility's own vehicle, or dues, subscriptions and licenses. "Salary" includes only the trainer wages. "Other" costs include registration fees, travel and per diem expenses, training supplies and contract trainer fees.

7850.1 Staff development Ancillary/Support – salary
7850.2 Staff development Ancillary/Support – other

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NON-REIMBURSABLE EXPENSES

These costs are described in rules under Chapter 5160-3 of the OAC, and are billable either to Medicare, directly to Medicaid by the provider of the item or service, or to other third-party payers.

9705 Legend Drugs
9710 Radiology
9715 Laboratory
9720 Non-Emergency Oxygen

9725 Other Non-Reimbursable – Specify Below.
Report costs for custom wheelchairs in this account.

9725.1 Other Non-Reimbursable – salary
9725.2 Other Non-Reimbursable – other

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9730 Late Fees, Fines or Penalties
Includes those fees, fines, or penalties as stated in CMS Publication 15-1 and audit fines assessed pursuant to section 5165.1010 of the Ohio Revised Code.

9735 Federal Income Tax
9740 State Income Tax
9745 Local Income Tax

9750 Insurance – Officer's Life
This is non-reimbursable expense when the facility is the beneficiary, except as referenced in CMS Publication 15-1, section 2130.

9755 Promotional Advertising and Marketing

9755.1 Promotional advertising/marketing – salary
9755.2 Promotional advertising/marketing – other

9760 Contributions and Donations
See CMS Publication 15-1, section 608

9765 Bad Debt

9770 Parenteral Nutrition Therapy

9776 Franchise Permit Fee
Franchise permit fee incurred by the provider. This is the franchise permit fee assessed by the Ohio Department Medicaid to nursing facilities. The provider shall report one hundred per cent of the franchise permit fee in account 9776. Franchise taxes are to be reported in account 6080, Franchise Tax.

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TABLE 8

CAPITAL COSTS

Capital costs means the actual expense incurred for all of the following:

(A) Depreciation and interest on any capital asset with a cost of five hundred dollars or more per item and a useful life of at least two (2) years. Provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the five hundred dollar criteria be exceeded.

(1) Buildings;
(2) Building improvements;
(3) Equipment;
(4) Extensive renovations;
(5) Transportation equipment;

(B) Amortization and interest on land improvements and leasehold improvements;
(C) Amortization of financing costs;
(D) Lease and rent of land, building, and equipment that does not qualify for account 7740 Leased Equipment.

Nursing facilities that did not change operator on or after 7/1/93 need only use group (A).

Nursing facilities that did change operator on or after 7/1/93 use groups (A) and (B).

GROUP (A) ASSETS ACQUIRED

8010 Depreciation – Building and Building Improvements
Depreciation of building and building improvements.

8020 Amortization – Land Improvements
Amortization expense for land improvements.

8030 Amortization – Leasehold Improvements
Leasehold improvements are amortized over the remaining life of the lease or the useful life of the improvement, but no less than five years. However, if the useful life of the improvement is less than five years, it may be amortized over its useful life. Options on leases will not be considered in the computation for amortization of leasehold improvements.

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8040 Depreciation – Equipment
Depreciation expense for equipment.

8050 Depreciation – Transportation equipment
Depreciation expense for transportation equipment.

8060 Lease and Rent – Building
Expense incurred for lease and rental expenses relating to buildings. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation accounts.

8065 Lease and Rent – Equipment
Expense incurred for lease and rental expenses relating to equipment. Capitalized assets as a result of lease obligations should be depreciated and included in the proper depreciation account. This account includes all leases effective after 12/01/92 for assets acquired prior to 7/01/93. (Cost of equipment, including vehicles, acquired by operating lease executed before 12/01/92 and the costs reported as administrative and general on the facility's cost report for period ending 12/31/92 are to be reported in account 7740.)

8070 Interest Expense – Property, Plant and Equipment
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for the acquisition of land, buildings and equipment.

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

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NONEXTENSIVE RENOVATIONS

Expenses for nonextensive renovations including depreciation, interest and amortization of financing cost completed prior to July 1, 2005.

8085 Depreciation/Amortization
Depreciation and amortization expenses for nonextensive renovations.

8086 Interest – Renovations
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for nonextensive renovation purposes.

8087 Amortization of Financing Cost – Renovations
Amortization expense for cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc. incurred for nonextensive renovations.
Amortization expense of long term financing costs such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc., acquired through a change of operator on or after 7/1/93.

8090 Home Office Costs/Capital Cost
Capital expenses of a separate division or entity that owns, leases or manages more than one facility (home office). These costs must be related to capital cost as specified in the capital cost center, and are allocated to the facility in accordance with CMS Publication 15-1, sections 2150 through 2150.3, "Home Office Costs." (All home office costs for group (A) are to be entered in this account. They are not to be distributed to any other account in this group.)

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GROUP (B) ASSETS ACQUIRED THROUGH A CHANGE OF OPERATOR

Nursing facilities, other than leased facilities, that changed operator on or after 7/1/93 use this group to report expenses incurred through a change of operator on or after 7/1/93. Leased nursing 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.

8110 Depreciation – Building and Building Improvements
Depreciation of building and building improvements acquired through a change of operator on or after 7/1/93.

8140 Depreciation – Equipment
Depreciation expense for equipment acquired through a change of operator on or after 7/1/93.

8170 Interest Expense – Property, Plant and Equipment
Interest expense incurred on mortgage notes, capitalized lease obligations, and other borrowing for the acquisition of land, buildings and equipment acquired through a change of operator on or after 7/1/93.

8180 Amortization of Financing Cost
Amortization expense of long term financing costs such as cost of issuing bonds, underwriting fees, closing costs, mortgage points, etc., acquired through a change of operator on or after 7/1/93.

8195 Lease Expense
Lease expenses incurred through a change of operator on or after 5/27/92.