ATTACHMENT 4.19-B

SECTION IV

WORKSHEET

OUTPATIENT CLINIC COST REPORT

PAGE 2

CONTRACT PERSONNEL - MEDICAL

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD : _____

MEDICAL SERVICES - NONSALARIED PERSONNEL - INTERNS AND RESIDENTS

NAME AND HOSPITAL AFFILIATION (1)	START MO./YR. (2)	ADMIN. DUTIES HOURS (3)	DIRECT CARE HOURS (4)	VACATION & SICK HOURS (5)	TOTAL HOURS (6)
1.	/				
2.	/				
3.	/				
4.	/				
5.	/				
6.	/				
7.	/				
8.	/				
9.	/				
10.	/				
11.	/				
12.	/				
13.	/				
14.	/				
15.	/				
16.	/				
17.	/				
18.	/				
19.	/				
20.	/				
21.	/				
22.	/				
23.	/				
24.	/				
25.	/				
26.	/				
27.	/				
28.	/				
29.	/				
30.	/				
31.	/				
32.	/				
33.	/				
34.	/				
35.	/				
36.	/				
37.	/				
38.	/				
39.	/				
40.	/				
41. TOTAL NONSALARIED PERSONNEL					

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #10

TN [redacted] 90-24
[redacted] DES
[redacted] NEW

APPROVAL DATE _____

EFFECTIVE DATE 1/1/91

SECTION IV WORKSHEET L

OUTPATIENT CLINIC COST REPORT

PAGE 3 OF

CONTRACT PERSONNEL – MENTAL & VISION

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD: _____

MENTAL HEALTH SERVICES – CONTRACTED – PSYCHOLOGIST & CLINICAL SOCIAL WORKERS

NAME AND TITLE	START MO./YR.	ADMIN. DUTIES		DIRECT CARE		VACATION & SICK		TOTAL	
		HOURS	COMP.	HOURS	COMP.	HOURS	COMP.	HOURS	COMP
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	/		$		$		$		$
2.	/								
3.	/								
4.	/								
5.	/								
6.	/								
7.	/								
8.	/								
9.	/								
10.	/								
11. TOTALS – CONTRACT PERSONNEL			$		$		$		$

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #5

VISION SERVICES – CONTRACTED – OPTOMETRIST, OPTICIAN

NAME AND TITLE	START MO./YR.	ADMIN. DUTIES		DIRECT CARE		VACATION & SICK		TOTAL	
		HOURS	COMP.	HOURS	COMP.	HOURS	COMP.	HOURS	COMP.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	/		$		$		$		$
2.	/								
3.	/								
4.	/								
5.	/								
6.	/								
7.	/								
8.	/								
9.	/								
10.	/								
11. TOTALS – CONTRACT PERSONNEL			$		$		$		$

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #7

TNS # 90-24 APPROVAL DATE 12/6/91
SUPERSEDES
TNS # NEW EFFECTIVE DATE 1/1/91

ODHS
1/91

SECTION IV

WORKSHEET

OUTPATIENT CLINIC COST REPORT

PAGE 4 O

CONTRACT PERSONNEL – DENTAL

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD: _____

DENTAL SERVICES – CONTRACTED – DENTISTS, DENTAL HYGIENIST, DENTAL DIRECTOR

NAME AND TITLE	START MO./YR.	ADMIN. DUTIES		DIRECT CARE		VACATION & SICK		TOTAL	
		HOURS	COMP.	HOURS	COMP.	HOURS	COMP.	HOURS	COM
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	/		$		$		$		$
2.	/								
3.	/								
4.	/								
5.	/								
6.	/								
7.	/								
8.	/								
9.	/								
10.	/								
11.	/								
12.	/								
13.	/								
14.	/								
15.	/								
16.	/								
17.	/								
18.	/								
19.	/								
20.	/								
21.	/								
22.	/								
23.	/								
24.	/								
25.	/								
26.	/								
27.	/								
28. TOTALS – CONTRACT PERSONNEL			$		$		$		$

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #3

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91

SECTION IV

WORKSHEET D-

OUTPATIENT CLINIC COST REPORT

PAGE 5 OF

CONTRACT PERSONNEL – PODIATRY & CHIROPRACTIC

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD: _____

PODIATRIC SERVICES – CONTRACTED – PODIATRIST

NAME AND TITLE	START MO./YR.	ADMIN. DUTIES		DIRECT CARE		VACATION & SICK		TOTAL	
		HOURS	COMP.	HOURS	COMP.	HOURS	COMP.	HOURS	COMP.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	/		$		$		$		$
2.	/								
3.	/								
4.	/								
5.	/								
6.	/								
7.	/								
8.	/								
9.	/								
10.	/								
11. TOTALS – CONTRACT PERSONNEL			$		$		$		$

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #11

CHIROPRACTIC SERVICES – CONTRACTED – CHIROPRACTOR

NAME AND TITLE	START MO./YR.	ADMIN. DUTIES		DIRECT CARE		VACATION & SICK		TOTAL	
		HOURS	COMP.	HOURS	COMP.	HOURS	COMP.	HOURS	COMP.
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
1.	/		$		$		$		$
2.	/								
3.	/								
4.	/								
5.	/								
6.	/								
7.	/								
8.	/								
9.	/								
10.	/								
11. TOTALS – CONTRACT PERSONNEL			$		$		$		$

CARRY TOTALS OVER TO SCHEDULE D-1, LINE #12

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91

SECTION V

SCHEDULE E

OUTPATIENT CLINIC COST REPORT

OTHER NON-REIMBURSABLE PROGRAM COSTS

NAME OF FACILITY: _____

PROVIDER #: _____ PERIOD: _____

SALARIES:

DIRECT SERVICE COST CENTER	WIC	SICKLE CELL	ADDITIONAL PROGRAMS	TOTAL
	(1)	(2)	(3)	(4)
1. MEDICAL SERVICE	$	$	$	$
2. LABORATORY				
3. RADIOLOGY				
4. DENTAL SERVICE				
5. SPEECH & HEARING THER				
6. MENTAL HEALTH				
7. PHYSICAL THERAPY				
8. TRANSPORTATION				
9. VISION CARE				
10. NUTRITIONISTS				
11. PODIATRIC				
12. CHIROPRACTIC				
13. SOCIAL WORKERS				
14. OTHER (SPECIFY):				
15.				
16.				
TOTAL	$	$	$	$

CONTRACT SERVICES & OTHER COSTS:

DIRECT SERVICE COST CENTER	WIC	SICKLE CELL	ADDITIONAL PROGRAMS	TOTAL
	(1)	(2)	(3)	(4)
1. MEDICAL SERVICE	$	$	$	$
2. LABORATORY				
3. RADIOLOGY				
4. DENTAL SERVICE				
5. SPEECH & HEARING THER				
6. MENTAL HEALTH				
7. PHYSICAL THERAPY				
8. TRANSPORTATION				
9. VISION CARE				
10. NUTRITIONISTS				
11. PODIATRIC				
12. CHIROPRACTIC				
13. SOCIAL WORKERS				
14. OTHER (SPECIFY):				
15.				
16.				
TOTAL	$	$	$	$

HAVE THESE COSTS BEEN INCLUDED ON SCHEDULE B-1, SECTIONS V THROUGH XIII? YES____ NO____

ODHS

SECTION V

SCHEDULE E-1

OUTPATIENT CLINIC COST REPORT

OTHER NON-REIMBURSABLE PROGRAM ENCOUNTERS

NAME OF FACILITY: _____

PROVIDER #: _____ PERIOD: _____

	DIRECT SERVICE COST CENTER	NON-REIMBURSABLE ENCOUNTERS
1	MEDICAL SERVICE	
2	LABORATORY	
3	RADIOLOGY	
4	DENTAL SERVICE	
5	SPEECH & HEARING THERAPY	
6	MENTAL HEALTH (INCLUDING CLINICAL SOCIAL WRKS.)	
7	PHYSICAL THERAPY	
8	TRANSPORTATION	
9	VISION CARE	
10	NUTRITIONISTS	
11	PODIATRIC	
12	CHIROPRACTIC	
13	SOCIAL WORKERS (NON-CLINICAL SOCIAL WORKERS)	
14	TOTAL	

ARE THESE ENCOUNTERS INCLUDED IN YOUR TOTAL REPORTED ENCOUNTERS ON SCHEDULE A OF THE COST REPORT? YES___ NO___

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/1/91

ODH

SECTION VI

SCHEDUL

OUTPATIENT CLINIC COST REPORT

COST OF SERVICES FROM RELATED ORGANIZATIONS

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD: _____

A. 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 organization as defined in the Health Insurance Manual (HIM-15), Chapter 10?

Yes ___ No ___ (If "Yes," complete Parts B and C)

B. Costs incurred as a result of transactions with related organizations.

Schedule	Line No.	Item	Amount	Cost to Related Organizatic
			$	$
			$	$
			$	$
			$	$

C. Name of related parties.

Name of Owner	Name of Related Organization	Percent of Ownership

Costs applicable to services, facilities and supplies furnished to the facility by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization (party). However, such cost must not exceed the price of comparable services, facilities or supplies that could be purchased elsewhere.

NOTE: See intructions for definition of "related."

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91

ODH:

OUTPATIENT CLINIC COST REPORT

NAME OF FACILITY: _____

ADDRESS: _____

PROVIDER NO. _____

FEDERAL I.D. NO. _____ COUNTY _____

CERTIFICATION STATEMENT

PAYMENT OF THIS CLAIM WILL BE MADE FROM FEDERAL AND STATE FUNDS. ANY INTENTIONAL FALSIFICATION OR CONCEALMENT OF A MATERIAL FACT MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF AGENCY

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT, AND THAT I HAVE EXAMINED THE ACCOMPANYING COST REPORT AND SUPPORTING WORKSHEETS FOR THE PERIOD _____ THROUGH _____ AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE AGENCY IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED.

SIGNED: _____
OFFICER OR ADMINISTRATOR OF ORGANIZATION

TITLE: _____

DATE: _____

REPORT PREPARED BY: _____

TELEPHONE NO. ( ) _____

[illegible]

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91

SECTION VII

SCHI

OUTPATIENT CLINIC COST REPORT

REVENUE TRIAL BALANCE

NAME OF FACILITY: _____ PROVIDER #: _____

PERIOD: _____

SOURCES

A.	ACCOUNT NAME:	MEDICAID	MEDICARE	G.A.	PRIVATE	OTHER	TOT
1.	Medical Services	$	$	$	$	$	$
2.	Laboratory						
3.	Radiology						
4.	Dental						
5.	Speech & Hearing Therapy						
6.	Mental Health						
7.	Physical Therapy						
8.	Transportation						
9.	Vision Care						
10.	Pharmacy						
11.	Podiatric						
12.	Chiropractic						
13.	Nutritionists						
14.	Social Workers						
15.	TOTAL DIRECT CARE REVENUE	$	$	$	$	$	$

B.	OTHER PROGRAMS:	AMOUNT	TOTA
1.	Women, Infants, & Children	$	$
2.	Sickle Cell		
3.	Homeless		
4.			
5.	City Grants		
6.	Federal Grants		
7.			
8.	Gifts		
9.	Contributions		
10.			
11.	TOTAL OTHER, GRANTS, GIFTS	$	$

C.	OTHER INCOME:	AMOUNT	TOTA
1.	Medical Records sold	$	$
2.	Vending Machine Sales		
3.	Sale of Scrap/waste		
4.	Rental Income–Space		
5.	Rental Income–Equipment		
6.	Jury Duty, Witness Fees		
7.			
8.			
9.	TOTAL OTHER INCOME	$	$

TOTAL LINES A–15, B–11, C–9		$

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91
EFFECTIVE DATE 1/4/91

EFFECTIVE DATE: JUN 27 1991

CERTIFICATION: Terry A. Wallace

JUN 17 1991
DATE

PROMULGATED UNDER RC SECTION 119.03

STATUTORY AUTHORITY RC SECTION 5111.02

RULE AMPLIFIES RC SECTIONS 5111.01, 5111.02, AND 5111.04

PRIOR EFFECTIVE DATE: 4/10/91 (EMER.)

TNS # 90-24
SUPERSEDES
TNS # NEW

APPROVAL DATE 12/6/91

EFFECTIVE DATE 1/1/91