

Note: This schedule is utilized to calculate the statewide average annual compensation cost limit for owners and relatives of owners. Wages are to include wages for sick pay, vacation pay, and other paid time off as well as any other compensation to be 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 Schedule B-1, 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 Schedule B-1, 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.)].

23. Attachment 7, Addendum for Disputed Cost

This Attachment is for the reporting of costs as specified in section 5111.26 of 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.

24. ODHS 2524, Attachment 3, Summary of Cost

Attach requested documentation as instructed.

25. ODHS 2524, Schedule A, Page 2 of 2, Certification by Officer of Provider

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. Any reimbursement methodology for NFs or ICFs-MR which is not addressed in the cost report instructions is located in Chapter 5101:3-3 of the OAC.

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.

TR # 92-02 APPROVAL DATE MAY 28 2008
SUPERSEDES
TR # 92-05 EFFECTIVE DATE 5/21/08
(Revised 8/07)

MEDICAID COST REPORT

Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded

Type of Cost Report Filing pursuant to OAC Rule 5101:3-3-20 and 5101:3-3-24 (Please check one of the following)		
<input type="checkbox"/> 4.1 Year-End	<input type="checkbox"/> 4.3 Change of Provider Agreement	<input type="checkbox"/> 4.5 Closed Facility
<input type="checkbox"/> 4.2 New Facility	<input type="checkbox"/> 4.4 Rate Reconsideration	<input type="checkbox"/> 4.6 Amended

This cost report must be received or postmarked pursuant to OAC Rule 5101:3-3-20 except for state operated ICFs-MR. 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 ORC Section 5111.26 (A) (2). Read instructions before completing the form. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, submit to Ohio Department of Human Services, Bureau of Long Term Care Administration, Audits and Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43266-0423

Provider Name	Medicaid Provider Number	Medicare Provider Number
Complete Address: Address (1) _____ Address (2) _____ City _____ State of Ohio Zip Code _____	Federal ID Number ODH ID Number County	Period Covered by Cost Report From: Through:

TYPE OF CONTROL (Please check one of the following)

<input type="checkbox"/> Proprietary for Profit <input type="checkbox"/> 1.1 Individual <input type="checkbox"/> 1.2 Partnership <input type="checkbox"/> 1.3 Corporation <input type="checkbox"/> 1.4 Other: specify control	Corp. Name _____ Address (1) _____ Address (2) _____ City _____ State _____ Zip Code _____	<input type="checkbox"/> Voluntary Nonprofit <input type="checkbox"/> 2.1 Church <input type="checkbox"/> 2.2 Other: specify control <input type="checkbox"/> 2.3 Church Corporation
<input type="checkbox"/> Nonfederal Government <input type="checkbox"/> 3.1 State <input type="checkbox"/> 3.4 City-County <input type="checkbox"/> 3.6 Other: specify control	<input type="checkbox"/> 3.2 County <input type="checkbox"/> 3.3 City <input type="checkbox"/> 3.5 Hospital	Name and Address of Owner of Real Estate _____ _____ Zip Code _____

TYPE OF FACILITY <input type="checkbox"/> 1. Nursing Facility <input type="checkbox"/> 2. ICF-MR Facility	Is Facility a Unit of a: <input type="checkbox"/> a. Hospital <input type="checkbox"/> b. Rehabilitation Center <input type="checkbox"/> c. Other; specify: _____	Name and Address of Owner (Operator) of Business _____ _____ Zip Code _____
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ALL PATIENTS 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) 6.1 Indirect allowable days (greater of line 4 or .85 X line 3) 6.2 Capital allowable days (greater of line 4 or .95 X line 3)	Medicaid Certified B (1) Total Facility Licensed Beds (2)
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OHIO MEDICAL ASSISTANCE PROGRAM PATIENTS 7. Total patient days (from Schedule A-1, line 13, column 5) 8. Utilization (line 7 divided by line 4, col. 1 X 100)	_____ _____
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EXCEPT AS PROVIDED IN OAC RULE 5101:3-3-53 (for Nursing Facilities)
EXCEPT AS PROVIDED IN OAC RULE 5101:3-3-86 (for ICFs/MR)
IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE _____

AND NUMBER OF BEDS INVOLVED _____

TN #9802 APPROVAL DATE MAY 28 1998
SUPERSEDES
TN #9203 EFFECTIVE DATE 3/31/98

CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, all cost reports submitted to ODHS 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) _____, 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(s)		Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider(s)		
(Last)	(First)	(M.I.)
Title	Telephone Number Area code ()	Fax Number Area Code ()

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

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

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this _____ day of _____ 19____ at _____, county of _____, and state of _____.

Signature of Notary

ODHS 2524 (REV. 8/97)

TR # 98-02 APPROVAL DATE MAY 28 1998
SUPERSEDES
TR # 97-05 EFFECTIVE DATE 3/31/98

SUMMARY OF INPATIENT DAYS

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
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Note: 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. NFs must report each medically necessary leave day and limited absence as 50% of an inpatient day. Please refer to rule 5101:3-3-59 of the OAC for details.

Month	Number of Medicaid Certified Beds (1)	Patient Days (Per Census) for Medicaid Patients Only				Non-Medicaid Eligible Patients			Inpatient Days for Patients (sum of col.5-8) (9)
		Authorized Days (2)	Hospital Leave Days* @50% (3)	Therapeutic Leave Days* @50% (4)	Total Medicaid Days (sum of col. 2-4) (5)	Private Days (6)	Medicare Days (7)	Veterans and Other Days (8)	
1. January									
2. February									
3. March									
4. April									
5. May									
6. June									
7. July									
8. August									
9. September									
10. October									
11. November									
12. December									
13. TOTAL (sum of lines 1 through 12)									
					to ODHS 2524 Schedule A line 7				to ODHS 2524 Schedule A line 4, col. 1

*CONSULT THE OHIO ADMINISTRATIVE CODE RULE 5101:3-3-59 (NFs) AND 5101:3-3-92 (ICF-MRs) FOR AN EXPLANATION OF THE DIFFERENCE BETWEEN HOSPITAL AND THERAPEUTIC LEAVE DAYS.

TN #98-02 APPROVAL DATE MAY 28 1998
SUPERSEDES
DATE 3/31/98

DETERMINATION OF MEDICARE PART B COSTS TO OFFSET

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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Instructions: List GROSS CHARGES for residents days shown in Schedule A-1 and Attachment 4. GROSS CHARGES must be reported from the uniform charge structure that is applicable to all residents.

SECTION A Description (1)	Medicare Part B Primary Payer is:		Private (4)	Medicare Part A Services (5)	Veteran and Other (6)	Medicaid (7)	Total Revenue (sum of cols. 2-7) (8)
	Medicaid (2)	Other (3)					
1a Medical Supplies Revenue							
1b Percentage (line 1a col. x divided by total on line 1a col. 8)							100%
2a Medical Minor Equipment							
2b Percentage (line 2a col. x divided by total on line 2a col. 8)							100%
3a Enteral Feeding Revenue							
3b Percentage (line 3a col. x divided by total on line 3a col. 8)							100%
4 TOTAL (Sum of 1a through 3a)							
SECTION B: COSTS (1)	MEDICARE PART B OFFSET CALCULATIONS						
	Medical Supplies (2)	Medical Minor Equip. (3)	Enterals (4)	Total Offset (5)			
5 Percent. of Medicare Part B Charges where primary payer is Medicaid (from Sch A-2, col. 2, applicable line b)							
6 Costs (from Schedule B-1, column 3, lines 1 and 4 and Schedule C column 3 line 11)							
7 Costs to be offset (line 5 times line 6). Offset costs in col. 4 on applicable cost report lines identified in line 6 of this section.							
SECTION C: INDIRECT COST - OFFSET							
8 Indirect costs (Schedule C line 63 column 3 less Sch. C lines, 18, 25, 34, 35, 36 and 55 col. 3)							
9 Total costs (total of Sch. B-1 line 19, B-2 line 56, C line 63, D lines 11, 13, 19, 30, and 44.)							
10 Line 8 divided by line 9							
11 Costs offset (from line 7 column 5 above)							
12 Indirect cost to be offset (line 10 times line 11) offset costs on Schedule C line 47 column 4							

SUMMARY OF COSTS

Provider Name		Medicaid Provider Number	Reporting Period			
			From:	Through:		
REIMBURSABLE COSTS		Reference Schedule Line (1)	Sub Total (2)	Total Cost (3)	Allowable Patient Days (4)	Filed Cost Per Diem [Col 3 / 4] (5)
OTHER PROTECTED COSTS						
1.	Other Protected Costs use allowable patient days Sch A line 4 Col 1	B-1 line 19 Col 7				
DIRECT CARE COST CENTER						
2.	Direct Care Cost	B-2 line 56 Col 7				
INDIRECT CARE COST CENTER						
3.	Indirect Care Cost use allowable patient days Sch A line 6.1 Col 1	C line 63 Col 7				
CAPITAL COST CENTER						
COST OF OWNERSHIP						
4.	Assets Acquired Group A	D line 11 Col 7				
5.	Assets thru Change of Ownership Group B	D line 19 Col 7				
6.	Total Cost of Ownership (sum of lines 4 and 5)					
RENOVATIONS COST CENTER						
7.	Renovations Group A	D line 13 Col 7				
8.	TOTAL Capital Cost (sum of lines 6 and 7) use allowable patient days Sch A line 6.2 Col 1					
EQUITY						
9.	Return on Equity	E-1 line 36 col 5				
10.	TOTAL Reimbursable Costs (sum of lines 1, 2, 3, and 8) Col 3					
11.	TOTAL Filed Cost Per Diem (sum of lines 1, 2, 3, 8, and 9) Col 5					

RECONCILIATION OF COSTS

Schedule/Line #	Total (1)	Adjustments: Increases (Decreases) (2)	Adjusted Total (3)	(Opt.) Allocated Adjusted Total (4)
12. B-1/19 col 3		col 4	col 5	col 7
13. B-2/56 col 3		col 4	col 5	col 7
14. C/93 col 3		col 4	col 5	col 7
15. D* col 3		col 4	col 5	col 7
16. Totals (A)	\$	(B)	\$	\$
17. Less Non-Reimbursable from Schedule C Page 3 line 92.....			col 5 ()	col 7 ()
18. Total Reimbursable.....			\$ (C)	\$ ()

- * Summary of Schedule D lines 11, 13, 19,
(A) Agrees to Total Expenses per Working Trial Balance.
(B) Agrees to Attachment 2, line 40, Column 4.
(C) Agrees to Schedule A-3, line 10, Column 3.

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

TN # 98-02 APPROVAL DATE MAY 28 1998
 SUPERCEDES
 TN # 92-05 EFFECTIVE DATE 3/31/98

OTHER PROTECTED COSTS

Name of Facility		Medicaid Provider Number			Reporting Period From:		Through:	
OTHER PROTECTED 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. Ratio *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
MEDICAL SUPPLIES								
1.	Medical Supplies - medicare billable	6000						
2.	Medical Supplies - medicare non-billable	6001						
3.	Oxygen - Emergency stand-by	6003						
4.	Medical Minor Equip. - medicare billable	6005						
5.	Medical Minor Equip. - medicare non-bill.	6006						
6.	TOTAL Medical Supplies (sum of lines 1 through 5)							
PRIOR AUTHORIZED MEDICAL EQUIP.								
7.	Prior Authorized Medical Equip.	6010						
UTILITY EXPENSES								
8.	Heat, Light, Power	6020						
9.	Water and Sewage	6030						
10.	Trash and Refuse Removal	6040						
11.	Hazardous Medical Waste Collection	6050						
12.	TOTAL Utility Costs (sum of lines 8 through 11)							
PROPERTY TAXES								
13.	Real Estate Taxes	6060						
14.	Personal Property Taxes	6070						
15.	Franchise Tax (Attach FT 1120)	6080						
16.	TOTAL Property Taxes (sum of lines 13 through 15)							
GOVERNMENT MANDATED FEES								
17.	Government Mandated Assessments/Fees	6090						
17a.	Franchise Permit Fees	6091						
17b.	Total Government Mandated Fees (sum of lines 17 and 17a)							
** HOME OFFICE COSTS **								
18.	** Home Office Costs/Other Protected **	6095						
NFs and ICFs - MR PAYROLL TAXES, FRINGE BENEFITS STAFF DEVELOP. (Other Protected Costs)								
19.	Payroll Taxes - Other Protected	6054						
20.	Workers Compensation - Other Protected	6055						
21.	Employee Fringe Benefits - Other Protected	6056						
22.	EAP Administrator - Other Protected	6057						
23.	Self Funded Programs Admn. - Other Protected	6058						
24.	Staff Development - Other Protected	6059						
25.	TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 19 thru 24)							
26.	TOTAL Other Protected Costs (sum of lines 6,7,12,16,17,18, & 25)							

**** HOME OFFICE COSTS INSTRUCTIONS: ****

Home office costs are to be entered on line 18 only. They are not to be distributed to any other line on this schedule.

Home office costs are only to be entered on the "Home Office" line on all schedules. They are not to be distributed to any other lines.

When ratios of allocation are used, limit the precision to four places to the right of the decimal.

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

APPROVAL DATE MAY 28 1998
 TN #98-02
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DIRECT CARE COST CENTER

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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DIRECT CARE COST CENTERS	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. Ratio *** (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. Activity Director	6135							
9. Activity Staff	6140							
10. Recreational Therapist for NFs	6145							
11. Program Specialist for ICFs-MR	6150							
12. Program Director	6155							
13. Habilitation Supervisor for NFs	6160							
14. Habilitation Supervisor for ICFs-MR	6165							
15. Habilitation Staff	6170							
16. Psychologist	6175							
17. Psychology Assistant	6180							
18. Respiratory Therapist	6185							
19. Social Work/Counseling	6190							
20. Social Services/Pastoral Care	6195							
21. Qualified Mental Retardation Professional	6200							
22. Quality Assurance	6205							
23. Consulting and Management Fees-Direct	6210							
24. Other Direct Care - Specify below	6220							
25. Home Office Costs/Direct Care	6230							
26. TOTAL Nursing and Habilitation/Rehabilitation (sum of lines 1 through 25)								
PURCHASED NURSING SERVICES								
27. Registered Nurse; Purchased Nursing	6300							
28. Licensed Practical Nurse; Purchased Nursing	6310							
29. Nurse Aides Purchased Nursing	6320							
30. TOTAL Purchased Nursing (sum of lines 27 through 29)								

Line 24 Other Direct Care - Specify below

Account Title	Salary Column 1	Other Column 2
Totals must tie to line 24, Col 1 & 2		

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

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DIRECT CARE COST CENTER

Provider Name		Medicaid Provider Number		Reporting Period From:		Through:		
DIRECT CARE COST CENTER	Chart of Acct	Salary Facility Employee (1)	Other/Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio *** (6)	Allocated Adjust. Total [Col 5xCol 6] (7)
NURSING FACILITIES ONLY NURSE AIDE TRAINING								
31.	In-House Trainer Wages	6400						
32.	Classroom Wages: Nurse Aides	6410						
33.	Clinical Wages: Nurse Aides	6420						
34.	Books and Supplies	6430						
35.	Transportation	6440						
36.	Tuition Payments	6450						
37.	Tuition Reimbursement	6455						
38.	Contractual Payments to Other NFs	6460						
39.	Registration Fees/Application Fees	6470						
40.	Employee Fringe Benefits	6490						
41.	TOTAL Nurse Aide Training - NFs (sum of lines 31 through 40)							
ICF-MR FACILITIES ONLY DIRECT CARE THERAPIES								
42.	Physical Therapist ICF-MR	6600						
43.	Physical Therapy Assistant ICF-MR	6605						
44.	Occupational Therapist ICF-MR	6610						
45.	Occupational Therapy Assistant ICF-MR	6615						
46.	Speech Therapist ICF-MR	6620						
47.	Audiologist ICF-MR	6630						
48.	TOTAL Direct Care Therapies ICF-MR (sum of lines 42 through 47)							
NFs and ICFs-MR PAYROLL TAXES, FRINGE BENEFITS, & STAFF DEVELOP. (No Purchased Nursing)								
49.	Payroll Taxes - Direct Care	6510						
50.	Workers' Compensation - Direct Care	6520						
51.	Employee Fringe Benefits - Direct Care	6530						
52.	EAP Administrator - Direct Care	6535						
53.	Self Funded Programs Admin. - Direct Care	6540						
54.	Staff Development - Direct Care	6550						
55.	TOTAL Payroll Taxes, Fringe Benefits, & Staff Development (sum of lines 49 thru 54)							
56.	TOTAL Reimbursable Direct Care Cost (sum of lines 26, 30, 41, 48 and 55)							

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

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

TN # 98-02 APPROVAL DATE MAY 28 1998
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TN # 97-05 EFFECTIVE DATE 3/31/98

INDIRECT CARE COST CENTER

Provider Name		Medicaid Provider Number		Reporting Period		Through:			
INDIRECT CARE COST CENTER		Chart of Acct	Salary Facility Employee (1)	Other/Contract Wages (2)	Total [Col 1+Col 2] (3)	Adjustments Increases (Decreases) (4)	Adjusted Total [Col 3+Col 4] (5)	Alloc. Ratio *** (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.	Food Out-Of-Facility (see *footnote)	7041							
9.	Employee Meals	7045							
10.	Contract Meals/Contract Meals Personnel	7050							
11.	Enterals: Medicare Billable	7055							
11a.	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, HABILITATION, PHARM. & INCONTINENCE SUPPLIES									
19.	Habilitation Supplies	7100							
20.	Medical/Habilitation Records	7105							
21.	Pharmaceutical Consultant	7110							
22.	Incontinence Supplies	7115							
23.	Personal Care - Supplies	7120							
24.	Program Supplies	7125							
25.	TOTAL Habilitation, Pharmaceutical & Incontinence (sum of lines 19 through 24)								
ADMINISTRATIVE & GENERAL SERVICES									
26.	Administrator	7200							
27.	Other Administrative Personnel	7210							
28.	Consulting and Management Fees-Indirect	7215							
29.	Office and Administrative Supplies	7220							
30.	Communications	7225							
31.	Security Services	7230							
32.	Travel and Entertainment	7235							
33.	SUB-TOTAL (sum of lines 26 through 32)								

*FOOTNOTE Total Number of meals purchased
Food Out-Of-Facility

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