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- (3) "FAILURE TO PAY" MEANS THAT AN INDIVIDUAL HAS A MEDICAID APPLICATION IN PENDING STATUS AND HAS FAILED, AFTER REASONABLE AND APPROPRIATE NOTICE, TO PAY OR TO HAVE THE MEDICARE OR MEDICAID PROGRAM PAY ON THE INDIVIDUAL'S BEHALF, FOR THE CARE PROVIDED BY THE NF OR ICF-MR. AN INDIVIDUAL SHALL BE CONSIDERED TO HAVE FAILED TO HAVE THE INDIVIDUAL'S CARE PAID FOR IF THE INDIVIDUAL HAS APPLIED FOR MEDICAID, IF BOTH OF THE FOLLOWING ARE THE CASE:
- (a) THE INDIVIDUAL'S APPLICATION, OR A SUBSTANTIALLY SIMILAR PREVIOUS APPLICATION, HAS BEEN DENIED BY THE COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES (CDJFS); AND
- (b) IF THE INDIVIDUAL APPEALED THE DENIAL PURSUANT TO DIVISION (C) OF SECTION 5101.35 OF THE REVISED CODE, AND THE DIRECTOR OF ODJFS UPHELD THE DENIAL.
- (4) "MEDICAID ELIGIBLE" MEANS AN INDIVIDUAL HAS BEEN DETERMINED ELIGIBLE AND HAS BEEN ISSUED AN EFFECTIVE DATE OF HEALTH CARE WHICH COVERS THE TIME PERIOD IN QUESTION BY THE CDJFS UNDER CHAPTER 5101:1-39 OF THE ADMINISTRATIVE CODE.
- (5) "OPERATOR" MEANS THE INDIVIDUAL, PARTNERSHIP, ASSOCIATION, TRUST, CORPORATION, OR OTHER LEGAL ENTITY THAT OPERATES A NF OR ICF-MR.
- (6) "VOLUNTARY WITHDRAWAL" MEANS THAT THE OPERATOR OF A NF, IN COMPLIANCE WITH SECTION 1919(c)(2)(F) OF THE SOCIAL SECURITY ACT, VOLUNTARILY ELECTS TO WITHDRAW FROM PARTICIPATION IN THE MEDICAID PROGRAM BUT CHOOSES TO CONTINUE PROVIDING SERVICES OF THE TYPE PROVIDED BY NFS. FOR ICFS-MR "VOLUNTARY

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WITHDRAWAL" MEANS THE OPERATOR ELECTS TO VOLUNTARILY TERMINATE FROM THE MEDICAID PROGRAM.

(A)(B) A PROVIDER OF A NF or ICF-MR shall:

- (1) Execute the provider agreement in the format provided by ~~ODHS~~ ODJFS; AND
- (2) Apply for and maintain a valid license to operate if required by legal philosophy; AND
- (3) Comply with all applicable federal, state, and local laws and rules; AND
- (4) Keep records and file reports as required in rule 5101:3-3-20 of the Administrative Code; AND
- (5) Open all records relating to the costs of its services for inspection and audit by ~~ODHS~~ ODJFS and otherwise comply with rule 5101:3-3-20 of the Administrative Code; AND
- (6) Supply to ~~ODHS~~ ODJFS such information as the department requires concerning NF or ICF-MR services to ~~residents~~ INDIVIDUALS who are medicaid eligible or who have applied to be medicaid recipients.

~~"Medicaid eligible" means an individual has been determined eligible and has been issued an effective date of health care which covers the time period in question by a county department of human services (CDHS) under Chapter 5101:1-39 of the Administrative Code.~~

- (7) ~~Retain~~ UNLESS THE CONDITIONS DESCRIBED IN PARAGRAPH (J) OF THIS RULE ARE APPLICABLE, RETAIN as a resident in the NF or ICF-MR any ~~person~~ INDIVIDUAL who is medicaid eligible, becomes medicaid eligible, or applies for medicaid eligibility. Residents in the NF or ICF-MR who are medicaid eligible, become medicaid eligible, or apply for medicaid eligibility, are considered residents in the NF or ICF-MR during any absence for

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which bed-hold days are reimbursed in accordance with rules 5101:3-3-59 and 5101:3-3-92 of the Administrative Code.

- (8) ~~Admit~~ UNLESS THE CONDITIONS DESCRIBED IN PARAGRAPH (J) OF THIS RULE ARE APPLICABLE, ADMIT as a resident in the NF or ICF-MR, ~~a person~~ AN INDIVIDUAL who is medicaid eligible, whose application for medicaid is pending, or who is eligible for both medicare and medicaid, and whose level of care determination is appropriate for the admitting facility. This applies only if less than eighty per cent of the total residents in the NF or ICF-MR are recipients of medicaid. ~~This provision does not require that any such resident be admitted if the individual requires a level of care or range of services that the NF or ICF-MR is not certified or otherwise qualified to provide.~~
- (a) In order to comply with these provisions, the NF or ICF-MR admission policy shall be designed to admit ~~residents~~ INDIVIDUALS sequentially based on the following:
- (i) The requested admission date; and
 - (ii) The date and time of receipt of the request; and
 - (iii) The availability of the level of care or range of services necessary to meet the needs of the applicants; and
 - (iv) Gender: sharing a room with a resident of the same sex (except married couples who agree to share the same room.)
- (b) The NF or ICF-MR shall maintain a written list of all requests for each admission. The list shall include the name of the potential resident; date and time the request was received; the requested admission date; and the reason for denial if not admitted. This list shall be made available upon request to the staff of ~~ODHS~~ ODJFS, ~~CDHS~~ CDJFS, and ~~ODH~~ THE OHIO DEPARTMENT OF HEALTH (ODH).

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(c) The following are exceptions to paragraph ~~(A)~~(B)(8) of this rule:

(i) BED-HOLD DAYS ARE EXHAUSTED.

Medicaid eligible residents of NFs who are on hospital stays; visiting with family and friends; or participating in therapeutic programs; and have exhausted coverage for bed-hold days under rule 5101:3-3-59 of the Administrative Code, must be readmitted to the first available semi-private bed in accordance with the provisions of rule 5101:3-3-59 of the the Administrative Code; or

(ii) FACILITY IS A COUNTY HOME.

Any county home organized under Chapter 5155. of the Revised Code may admit ~~residents~~ INDIVIDUALS exclusively from the county in which the county home is located; or

(iii) FACILITY HAS A RELIGIOUS SPONSOR.

Any religious or denominational NF or ICF-MR that is operated, supervised, or controlled by a religious organization may give preference to persons of the same religion or denomination; or

(iv) NF HAS CONTINUING CARE CONTRACTS.

A NF may give preference to persons with whom it has contracted to provide continuing care.

~~"Continuing care" refers to the living setting which provides the resident with an apartment or lodging; meals; maintenance services; and when necessary, nursing home care. All services are provided on the premises of the continuing care community. The~~

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~~resident signs a contract which identifies the continuum of services to be covered by the resident's initial entrance fee and subsequent monthly charges. If a continuing care contract provides for a living arrangement which specifically states that all health care services including nursing home services are met in full, medicaid payment cannot be made for those services covered by the contract. If a continuing care contract provides for only a portion of the resident's health care services, that portion shall be deducted from the actual cost of nursing home care and medicaid shall recognize the difference up to the medicaid maximum per diem.~~

(v) **PROLONGED "MEDICAID PENDING" APPLICATION STATUS.**

A NF or ICF-MR may decline to admit a medicaid applicant if that facility has a resident whose application was pending upon admission and has been pending for more than sixty days, as verified by the ~~EDHS~~ CDJFS. The NF or ICF-MR shall submit the necessary documentation in a timely manner as required in rules ~~5101:3-3-151~~ 5101:3-3-15.1 and ~~5101:3-3-153~~ 5101:3-3-15.3 of the Administrative Code.

(9) Effective July 1, 1997 and thereafter, provide the following necessary information to ~~EDHS~~ ODJFS and ~~EDHS~~ CDJFS to process records for payment and ~~adjustment~~ **ADJUSTMENT**:

(a) Submit the "facility/~~EDHS~~ CDJFS transmittal" (~~EDHS~~ JFS 09401) to the ~~EDHS~~ CDJFS to inform the ~~EDHS~~ CDJFS of any information regarding a specific resident for maintenance of current and accurate payment records at the ~~EDHS~~ CDJFS and the facility; and

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- (b) Submit the "facility payment and adjustment authorization" (~~ODHS~~ JFS 09400) directly to ~~ODHS~~ ODJFS to initiate, terminate or adjust vendor payment on a specific resident as required.
- (10) Permit access to facility and records for inspection by ~~ODHS~~ ODJFS, ~~ODH~~, ~~ODHS~~ CDJFS, representatives of the office of the state long-term care ombudsman, and any other state or local government entity having authority to inspect, to the extent of that entity's authority.
- (11) In the case of a change of provider agreement as defined in rules ~~5101:3-3-516~~ 5101:3-3-51.6 and ~~5101:3-3-845~~ 5101:3-3-84.5 of the Administrative Code, or dissolution of a business, follow the procedures in paragraphs ~~(A)~~(B)(11)(a) to ~~(A)~~(B)(11)(c) of this rule.
- (a) The ~~current~~ EXITING provider must provide a written notice to ~~ODHS~~ ODJFS, as provided in rules ~~5101:3-3-516~~ 5101:3-3-51.6 and ~~5101:3-3-845~~ 5101:3-3-84.5 of the Administrative Code, at least forty-five days prior to the effective date of any contract of sale or new lease agreement for the NF or ICF-MR.
- (b) The provider must submit documentation of any transaction (i.e., sales agreement, contract or lease) as requested by ~~ODHS~~ ODJFS to determine whether a change of provider has occurred as specified in rules ~~5101:3-3-516~~ 5101:3-3-51.6 and ~~5101:3-3-845~~ 5101:3-3-84.5 of the Administrative Code.
- (c) The ~~new provider~~ ENTERING OPERATOR, ~~upon acceptance of a new provider agreement,~~ shall submit an application for participation in the medicaid program and a written statement of intent to abide by ~~ODHS~~ ODJFS rules, the provisions of the new provider agreement; and any existing statement of deficiencies and plan of correction (HCFA 2567) submitted by the previous provider.
- (12) Assure the security of all personal funds of residents in accordance with rules 5101:3-3-60 and 5101:3-3-93 of the Administrative Code.

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- ~~(13)~~—~~Terminate the provider agreement by providing ODHS, the resident, or guardian, and the residents' sponsors, a written notice at least ninety days prior to the termination. A NF or ICF-MR that does not issue the proper notice is subject to the penalties specified in rules 5101:3-3-516 and 5101:3-3-845 of the Administrative Code.~~
- ~~(14)~~—(13) Comply with Title VI and Title VII of the Civil Rights Act of 1964 and Public Law 101-336 (the Americans with Disabilities Act of 1990), and shall not discriminate against any resident on the basis of race, color, age, sex, creed, national origin, or disability.
- ~~(15)~~—(14) Provide to ~~ODHS~~ ODJFS, through the court of jurisdiction, notice of any action brought by THE provider in accordance with Title 11 of the United States Code (bankruptcy). Notice shall be mailed to: "Office of Legal Services, Ohio Department of Human JOB AND FAMILY Services, 30 East Broad Street-31st. Floor, Columbus, Ohio ~~43215~~ 43215-3414."

~~(B)~~(C) A PROVIDER OF A NF shall:

- (1) Provide a statement to the ~~resident~~ INDIVIDUAL explaining the ~~resident's~~ INDIVIDUAL'S obligation to reimburse the cost of care provided during the application process, if it is not covered by medicaid.
- (2) Comply with the requirements in paragraph (F) of rule ~~5101:3-3-041~~ 5101:3-3-04.1 of the Administrative Code and repay ~~ODHS~~ ODJFS the federal share of payments under the circumstances required by sections 5111.45 and 5111.58 of the Revised Code.
- (3) DURING A CLOSURE OR VOLUNTARY WITHDRAWAL FROM THE MEDICAID PROGRAM PROVIDE ODJFS, THE RESIDENT OR GUARDIAN, AND THE RESIDENTS' SPONSORS A WRITTEN NOTICE AT LEAST NINETY DAYS PRIOR TO THE CLOSURE OR VOLUNTARY WITHDRAWAL. A NF THAT DOES NOT ISSUE THE PROPER NOTICE IS SUBJECT TO THE PENALTIES SPECIFIED IN RULE 5101:3-3-51.6 OF THE ADMINISTRATIVE CODE.

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(D) A PROVIDER OF AN ICF-MR SHALL:

- (1) DURING A "CLOSURE" OR "VOLUNTARY WITHDRAWAL" FROM THE, MEDICAID PROGRAM PROVIDE ODJFS; THE RESIDENT OR GUARDIAN, AND THE RESIDENTS' SPONSORS; A WRITTEN NOTICE AT LEAST NINETY DAYS PRIOR TO THE CLOSURE" OR "VOLUNTARY WITHDRAWAL". A ICF-MR THAT DOES NOT ISSUE THE PROPER NOTICE IS SUBJECT TO THE PENALTIES SPECIFIED IN RULE 5101: 3-3-84.5 OF THE ADMINISTRATIVE CODE.

~~(E)~~(E) A PROVIDER OF A NF or ICF-MR shall not:

- (1) Charge fees for the application process of a medicaid ~~resident~~ INDIVIDUAL or applicant.
- (2) Charge a medicaid ~~resident~~ INDIVIDUAL an admission fee.
- (3) Charge a medicaid ~~resident~~ INDIVIDUAL an advance deposit.
- (4) Require a third party to accept personal responsibility for paying the facility charges out of his or her own funds. However, the facility may require ~~an individual~~ A REPRESENTATIVE who has legal access to a ~~resident's~~ INDIVIDUAL'S income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the ~~resident's~~ INDIVIDUAL'S income or resources if the ~~resident's~~ INDIVIDUAL'S medicaid application is denied and if the ~~resident's~~ INDIVIDUAL'S cost of care is not being paid by medicare or another third-party payor. A third-party guarantee is not the same as a third-party payor (i.e, an insurance company), and this provision does not preclude the facility from obtaining information about medicare and medicaid eligibility or the availability of private insurance. The prohibition against third-party guarantees applies to all ~~residents~~ INDIVIDUALS and prospective ~~residents~~ INDIVIDUALS in all certified NFs or ICFs-MR regardless of payment source. Notwithstanding the above, this provision does not prohibit a third party from voluntarily making payment on behalf of a ~~resident~~ AN INDIVIDUAL.

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~~(D)~~(F) ~~ODHS~~ ODJFS shall:

- (1) Execute a provider agreement in accordance with the certification provisions set forth by the secretary of health and human services and ODH.
- (2) In the case of a change of ~~provider agreement~~ OPERATOR, issue a new provider agreement to the ~~new provider~~ ENTERING OPERATOR contingent upon the ~~new provider's~~ ENTERING OPERATOR'S compliance with paragraph ~~(A)~~(B)(11)(c) of this rule.
- (3) Provide copies of ~~ODHS~~ ODJFS rules governing the facility's participation as a provider in the medical assistance program. Whenever ~~ODHS~~ ODJFS files a proposed rule; or proposed rule in revised form under division (D) of section 111.15, or division (B) of section 119.03 of the Revised Code; the department shall provide the facility with one copy of such rule. In the case of a rescission or proposed rescission of a rule, ~~ODHS~~ ODJFS may provide the rule number and title instead of the rules rescinded or proposed to be rescinded.
- (4) Make payments in accordance with Chapter 5111. of the Revised Code and Chapter 5101:3-3 of the Administrative Code to the NF or ICF-MR for services to ~~residents~~ INDIVIDUALS eligible and approved for vendor payment under the medicaid program. ~~Payments shall be made no later than the fifteenth day of the month following the month in which care and services are provided to residents, with the following exceptions:~~
 - ~~(a) Payment shall be made no later than the fifteenth day of the second calendar month following: the month in which a resident was determined to be eligible; or the month the resident's medicare benefit has exhausted. Notification must be submitted to the CDHS during the month in which eligibility is determined, or in the month medicare benefits are exhausted. The effective date of authorization for payment shall be made in accordance with rules 5101:3-3-15, 5101:3-3-151, 5101:3-3-152 and 5101:3-3-153 of the Administrative Code.~~

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~~(b) The first payment shall be made no later than sixty days following the date of authorized admission.~~

~~(E)~~(G) ~~ODHS~~ ODJFS may terminate, suspend, not enter into, or not renew, the provider agreement upon thirty days written notice to the provider for violations of Chapter 5111. of the Revised Code; Chapters 5101:3-1 and 5101:3-3 of the Administrative Code; and if applicable, subject to Chapter 119. of the Revised Code.

~~(F)~~(H) Any NF or ICF-MR violating provisions defined in paragraphs ~~(A)~~(B)(7) and ~~(A)~~(B)(8) of this rule will be subject to a penalty in accordance with provisions of section 5111.99 of the Revised Code.

~~(G)~~(I) The ~~ODHS~~ CDJFS shall use the "facility/~~ODHS~~ CDJFS transmittal" (~~ODHS~~ JFS 09401) to inform the NFs and ICFs-MR of any information regarding a specific resident INDIVIDUAL necessary for maintenance of current and accurate payment records at the ~~ODHS~~ CDJFS and the facility.

(J) EXCLUSIONS.

THE PROVISIONS OF PARAGRAPH (B)(7) AND (B)(8) OF THIS RULE DO NOT REQUIRE AN INDIVIDUAL TO BE ADMITTED OR RETAINED AT THE NF OR ICF-MR IF THE INDIVIDUAL MEETS ONE OF THE FOLLOWING:

- (1) THE INDIVIDUAL REQUIRES A LEVEL OF CARE OR RANGE OF SERVICES THAT THE NF OR ICF-MR IS NOT CERTIFIED OR OTHERWISE QUALIFIED TO PROVIDE; OR
- (2) THE INDIVIDUAL HAS A MEDICAID APPLICATION IN PENDING STATUS AND MEETS THE DEFINITION OF "FAILURE TO PAY" IN THIS RULE.

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Review date: _____

Certification: _____

Date

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Statutory Authority: RC Section 5111.02, 3721.13
Rule Amplifies: RC Sections 5111.01, 5111.02, 5111.22, 5111.31
Prior Effective Dates: 7/3/80, 7/7/80, 9/1/82, 11/10/83, 1/30/85 (Emer.), 7/1/85,
8/1/87, 9/30/87 (Emer.), 12/28/87, 3/30/88, 1/1/95, 7/1/97

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5101:3-3-20.1 Nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR): Chart of Accounts.

The Ohio department of job and family services (ODJFS) requires that all facilities file semiannual cost reports through December 31, 1993, and annually thereafter, to comply with section 5111.26 of the Revised Code. The use of the chart of accounts in table 1 through table 8 of this rule is recommended to establish the minimum level of detail to allow for cost report preparation. If the recommended chart of accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report. Where a chart of account number has sub-accounts, it is recommended that the sub-accounts capture the information requested so that the information will be broken out for cost reporting purposes. For example, when revenue accounts appear by payor type, it is required that those charges be reported by payor type where applicable; when salary accounts are differentiated between "supervisory" and "other", it is required that this level of detail be reported on the cost report where applicable.

While the following chart of accounts facilitates the level of detail necessary for medicaid cost reporting purposes, providers may find it desirable or necessary to maintain their records in a manner that allows for greater detail than is contained in the recommended chart of accounts. For that reason, the recommended chart of accounts allows for a range of account numbers for a specified account. For example, account 1001 is listed for petty cash, with the next account, cash, beginning at account 1010. Therefore, a provider could delineate sub-accounts 1010-1, 1010-2, 1010-3, 1010-4, through 1010-9 as separate petty cash accounts. Providers need only use the sub-accounts applicable for their facility.

Within the expense section (tables 5, 6, and 7), accounts identified as "salary" accounts are only to be used to report wages for facility employees. 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. Expense accounts identified as "contract" accounts are only to be used for reporting the 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. Expense accounts identified as "purchased nursing services" are only to be used for reporting the costs incurred for personnel acquired through a nursing pool agency. Expense accounts designated as "other" can be used for reporting any appropriate nonwage expenses, including contract services and supplies.

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Completion of the cost report as required in section 5111.26 of the Revised Code will require that the number of hours paid be reported (depending on facility type of control, on an accrual or cash basis) for all salary expense accounts. Thus, providers' record keeping should include accumulating hours paid consistent with the salary accounts included within the recommended chart of accounts.

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 Payors

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

1040 Allowance for Uncollectible Accounts Receivable

This account represents the estimated amount of uncollectible receivables.

1050 Notes Receivable

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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 LTCF supplies.

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 which will be charged to future accounting periods.

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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 7225. Amortized cost of prior authorized medical equipment should be reported in account 6010.

1200 Property, Plant and Equipment

[All ICFs-MR need only use groups (A) and (C).]

Nursing facilities that did not change ownership on or after 7/01/93 need only use groups (A) and (C). Nursing facilities that did change provider agreement on or after 7/01/93 use groups (A), (B), and (C).

- (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 cost, mortgage points, etc.

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

- 1200-8 - Land acquired on or after 7/01/93 through a change of provider agreement
- 1200-9 - Building and building improvements

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- 1200-10 - acquired on or after 7/01/93 through a change of provider agreement
- 1200-10 - Equipment acquired on or after 7/01/93 through a change of provider agreement

(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

1250 Accumulated depreciation and amortization-prop., plant, equip.
[All ICFs-MR need only use groups (A) and (C).]

Nursing facilities that did not change ownership on or after 7/01/93 need only use groups (A) and (C). Nursing facilities that did change provider agreement on or after 7/01/93 use groups (A), (B), and (C).

- (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 cost, mortgage points, etc.

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

- 1250-7 - Building and building improvements acquired on or after 7/01/93 through a change of provider agreement
- 1250-8 - Equipment acquired on or after 7/01/93 through a change of provider agreement

(C) (Assets under capital lease)

- 1250-15 - Assets under capital lease - prior to 5/27/92
- 1250-16 - Assets under capital lease - on or after 5/27/92

1300 Renovations-as defined in section 5111.25 of the Revised Code.

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[All NFs AND ICFs-MR need only use groups (A) and (B).]

- (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 cost, 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 - renovations

[All NFs AND ICFs-MR need only use groups (A) and (B).]

- (A) 1350-1 - Building and building improvements
 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

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

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- 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.

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

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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

~~Table 2 cont:~~

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.

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 PERS
- 2060-6 - Group insurance premium
- 2060-7 - State unemployment taxes
- 2060-8 - Federal unemployment taxes
- 2060-9 - Worker's compensation
- 2060-10 - Union dues

2080 Taxes Payable

- 2080-1 - Real estate
- 2080-2 - Personal property

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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

Table 2-cont.

2090 Other Liabilities

2090-1	-	Accrued interest
2090-2	-	Dividends payable
2090-3	-	Other
2090-4	-	Franchise permit fee

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 "Health Care Financing Administration (HCFA) Publication 15-1", Section 1210, previously entitled "HIM 15, Health Insurance Manual."

2450 Deferred Liabilities

2450-1	-	Revenue
2450-2	-	Federal income taxes
2450-3	-	State income taxes
2450-4	-	Local income taxes

Table 3

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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

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 which are billable to medicare regardless of payor 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 which are not billable to medicare regardless of payor type.

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5090 Medical Minor Equipment - Medicare
Items which are billable to medicare regardless of payor 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 which are not billable to medicare regardless of payor type.

5110 Enteral Nutrition Therapy - Medicare
Items which are billable to medicare regardless of payor 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 which are not billable to medicare regardless of payor type.

- 5130 Habilitation Supplies
- 5140 Incontinence Supply
- 5150 Personal Care
- 5160 Laundry Service - Routine

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

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- 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

DEDUCTIONS FROM REVENUES

- 5710 Contractual Allowance - Medicare
- 5720 Contractual Allowance - Medicaid
- 5730 Contractual Allowance - Other

A single account which is the sum of 5710, 5720 and 5730 can be maintained by those LTCFs that do not record contractual allowances by payment source. Detail supporting this single account must be available.

- 5740 Charity Allowance

Table 5

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OTHER PROTECTED COST

MEDICAL SUPPLIES

Medical supplies - items which 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; 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 6001. For those facilities participating in both the medicare and medicaid programs, medical supplies must be categorized and classified as follows:

- 6000 Medical Supplies Billable to Medicare - Medical supplies for facilities participating in medicare which are billable to medicare regardless of payor type.
- 6001 Medical Supplies Non-Billable to Medicare - Medical supplies for facilities not participating in medicare, as well as medical supplies for facilities which are not billable to medicare regardless of payor type.
- 6003 Oxygen - Oxygen defined as emergency stand-by oxygen only, all other oxygen should be directly billed by supplier to medicaid.

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 7350.

For those facilities participating in medicaid and not in medicare, all medical minor equipment should be classified in account 6006. For those facilities participating in both the medicare and medicaid programs, medical minor equipment must be categorized and classified as follows:

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- 6005 Medical Minor Equipment Billable to Medicare - Medical minor equipment for facilities participating in medicare which are billable to medicare regardless of payor type.
- 6006 Medical Minor Equipment Non-Billable to Medicare - Medical minor equipment for facilities not participating in medicare, as well as medical minor equipment for facilities which are not billable to medicare regardless of payor type.

PRIOR - AUTHORIZED MEDICAL EQUIPMENT

Equipment authorized and purchased prior to July 1, 1993.

- 6010 Prior Authorized Medical Equipment - Amortized or lease expenses of prior authorized specialized medical equipment. Provider must have received an approval letter from (ODJFS), division of long term care, before expenses can be reported. A copy of the approval letter must be sent with the cost report. Examples-include but are not limited to: ventilators (all types), enteral feeding pumps, IV infusion pumps, oxygen concentrators, decubitus care beds, miscellaneous request items in LTCFs (not listed on the formulary), and LTCF requests for prior-authorization for facility purchases).

UTILITY EXPENSES

- 6020 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).
- 6030 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, which are used on the water and sewer system.

6030.1	-	Water and sewage salary
6030.2	-	Water and sewage other

~~table 5 cont.~~

- 6040 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.)

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