



5101:3-2-23

**Cost reports.**

(A) For cost-reporting purposes, the medicaid program requires each eligible provider, as defined in rule 5101:3-2-01 of the Administrative Code, to submit periodic reports which generally cover a consecutive twelve-month period of their operations. Cost reports must be filed within one hundred eighty days of the end of the hospital's cost-reporting year. Extensions of this one hundred eighty day period shall be granted if the ~~health care financing administration~~ centers for medicare and medicaid services (CMS) of the United States department of health and human services extends the date by which the hospital must submit its cost report for the hospital's cost-reporting period. Failure to submit all necessary items and schedules will only delay processing and may result in a reduction of payment or termination as a provider as described in paragraph (H) of this rule.

Failure to submit cost reports on or before the dates specified shall be fined one hundred dollars for each day after the due date that the information is not submitted. Effective for medicaid cost reports filed for cost reporting periods ending in state fiscal year (SFY) 2003, and each cost reporting period thereafter, any hospital that fails to submit cost reports on or before the dates specified by the department shall be fined one thousand dollars for each day after the due date that the information is not reported.

The hospital shall complete and submit the JFS 02930 in accordance with instructions contained in this rule. The JFS 02930 for SFY ~~2001~~2002 and its instructions are shown in appendix A of this rule. The hospital's cost report must:

- (1) Be prepared in accordance with medicare principles governing reasonable cost reimbursement set forth in the providers' reimbursement manual "~~HCFACMS~~ Publications 15 and 15-1", available at [www.cms.hhs.gov/manuals/cmstoc.asp](http://www.cms.hhs.gov/manuals/cmstoc.asp) dated November 08, 2002 ;
- (2) Include all information necessary for the proper determination of costs payable under medicaid including financial records and statistical data;
- (3) Include as an attachment a copy of the medicare cost report which must be identical in all respects to the cost report submitted to the medicare fiscal intermediary-;
- (4) Include the cost report certification executed by an officer of the hospital attesting to the accuracy of the cost report. In addition, all subsequent revisions to the cost report must include an executed certification;
- (5) Effective for medicaid cost reports filed for cost reporting periods ending in SFY 2003, and each cost reporting period thereafter, the executed certification shall require the officer of the hospital to acknowledge that an independent party, a certified public accountant, has successfully verified the

data reported on "Schedule F" of the cost report in accordance with the procedures included in the cost report instructions.

- (B) Hospitals having a distinct part psychiatric or rehabilitation unit recognized by medicare in accordance with the provisions of 42 CFR 412.25 effective October 1, 2002, 42 CFR 412.27 effective October 1, 1994, and 42 CFR 412.29 effective January 1, 2002, must identify distinct part unit costs separately within the cost report as described in paragraph (A) of this rule.
- (C) Ohio hospitals performing transplant services covered under medicaid as described in rule 5101:3-2-07.1 of the Administrative Code must identify transplant costs, charges, days, and discharges separately within the cost report as described in paragraph (A) of this rule.
- (D) Ohio hospitals performing ambulatory surgery within the hospital outpatient setting must identify ambulatory surgery costs and charges separately within the cost report as described in paragraph (A) of this rule.
- (E) Ohio hospitals providing services to medicaid managed care plan (MCP) enrollees must identify MCP costs and charges separately within the cost report as described in paragraph (A) of this rule.
- (F) It is not necessary to wait for the medicare (Title XVIII) audit in order to file the first interim cost report filing. The interim cost report filing can be audited by the Ohio department of job and family services prior to any applicable final adjustment and settlement. If an amount is due ODJFS as a result of the filing, payment must be forwarded, in accordance with the instructions in appendix A, at the time the cost report is submitted for it to be considered a complete filing. Any revised interim cost report must be received within thirty days of the provider's receipt of the interim cost settlement. A desk audit will be performed by the hospital audit section on all interim cost reports. An interim cost settlement by the department does not preclude the finding of additional cost exceptions in a final settlement for the same cost-reporting period.
- (1) If an amended medicare cost report is filed with the medicare fiscal intermediary, a copy of the amended medicare cost report must be filed with the hospital audit section. Information contained in the amended medicare cost report will be incorporated into the interim cost report, as originally filed, if received prior to interim settlement; otherwise, it is subject to the provisions of paragraph (F) of this rule.
- (2) Adjustments may be made to the interim cost report as described in rule 5101:3-2-24 of the Administrative Code.

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(G) Out-of-state providers of inpatient and/or outpatient services to eligible Ohio Title XIX recipients will not be required to file the cost report identified in this rule unless the outpatient billings for services furnished within their reporting period equal or exceed three hundred thousand dollars.

(H) Delinquent filing of medicaid cost reports

Hospitals that fail to submit cost reports timely as defined in paragraph (A) of this rule will receive a delinquency letter from the department and are subject to notification that thirty days following the date on which the cost report was due, payments for hospital services will be suspended. Suspension of payments will be terminated on the fifth working day following receipt of the delinquent cost report. Claims affected by suspension of payment are not considered to be clean claims as "clean claims" are defined in rule 5101:3-1-19.3 of the Administrative Code. At the beginning of the third month following the month in which the hospital cost report became overdue, if the cost report has not yet been submitted, termination of the provider from the program will be recommended in accordance with Chapter 5101:3-1 of the Administrative Code.

(I) Termination of reasonable cost reimbursement for inpatient hospital services furnished by hospitals subject to prospective payment and certain outpatient hospital services.

As identified in rule 5101:3-2-07.1 of the Administrative Code, certain hospitals are subject to prospective payment for inpatient services provided on and after October 1, 1984. The hospital must submit on an annual basis a cost report representative of the fiscal year period for the hospital.

As identified in rule 5101:3-2-21 of the Administrative Code, certain outpatient services are no longer subject to reasonable cost reimbursement effective with services delivered on or after July 1, 1988. Hospitals must continue to submit on an annual basis a cost report representative of the fiscal reporting period for the hospital, regardless of whether such costs are for services not subject to reasonable cost reimbursement.

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Effective: 03/27/2003

R.C. 119.032 review dates: 03/01/2006

CERTIFIED ELECTRONICALLY

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Certification

03/17/2003

\_\_\_\_\_  
Date

Promulgated Under: 119.03  
Statutory Authority: 5111.02  
Rule Amplifies: 5111.01, 5111.02  
Prior Effective Dates: 4/7/77, 12/30/77, 3/21/81,  
11/11/82, 1/1/84, 10/1/84,  
7/29/85, 10/1/85 (Emer.),  
12/22/85, 10/19/87, 4/23/88,  
8/1/88 (Emer.), 10/21/88,  
2/22/89 (Emer.), 5/8/89,  
11/5/89, 5/25/90, 5/1/91,  
5/1/92, 10/1/93 (Emer.),  
11/15/93, 1/20/95, 3/16/96,  
7/1/96, 7/1/97, 4/26/99,  
7/15/99, 10/18/99, 5/1/00,  
5/17/2001

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SFY 2002 MEDICAID COST REPORT  
GENERAL INSTRUCTIONS

Please read and follow all instructions carefully. *Instructions that pertain to DRG-exempt and out-of-state hospitals will be in italics throughout the cost report instructions.* If you have questions about the instructions or report please contact Kurt Brooks of the Hospital Unit, (614) 644-2190.

The cost report schedules should be completed in order, from A to I. Within the report, the line numbers for the revenue centers are set up to closely match the HCFA-2552-96 in order to allow for easy transfer of data.

UB-92 revenue center codes should be grouped as shown on the attached sheets for inpatient and outpatient services. If this is not possible **YOU MUST** specifically identify any differences in groupings on the enclosed BILLING CODE ALLOCATION sheet(s) and return them with the completed cost report. When differences in groupings exist but are not identified by the report filer, ODJFS groupings will be used at the time of settlement.

Report only data and discharges occurring within the fiscal period covered by this cost report.

FILING DEADLINE

Any hospital that fails to submit cost reports on or before the dates specified by the department shall be fined one hundred dollars (\$100.00) for each day after the due date that the information is not reported.

The completed cost report **MUST BE POSTMARKED on or before December 2, 2002** (a change) for those hospitals filing with a cost reporting period ending between July 31, 2001 and December 31, 2001. For those hospitals filing for other cost report periods between January 1, 2002 and June 30, 2002, the report is to be postmarked no later than December 31, 2002.

*Effective for Medicaid Cost Reports filed for cost reporting periods ending in State Fiscal Year (SFY) 2003, and each cost reporting period thereafter, any hospital that fails to submit cost reports on or before the dates specified by the department shall be fined one thousand dollars (\$1,000.00) for each day after the due date that the information is not reported.*

REQUIRED FILINGS

Your completed cost report filing **MUST** include:

- the completed HCFA 2552-96
- all completed applicable JFS 02930 [Formerly ODHS 2930] schedules
- diskette containing completed cost report
- **Mail cost report information to:**  
Bureau of Health Plan Policy, Hospital Unit  
30 E. Broad Street, 27th Floor  
Columbus, OH 43215-3414

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- remittance for amounts due with copy of settlement page should be mailed to:  
Ohio Department of Job and Family Services  
P.O. Box 182367  
Columbus OH 43218-2367

- Make checks payable to: Treasurer of State, State of Ohio (ODJFS)

Incomplete filings are subject to the \$100 per day fine described above. **Effective for cost reporting periods ending in State Fiscal Year (SFY 2003), incomplete filings will be subject to the \$1,000 per day fine described above.**

#### FILING EXTENSIONS

Requests for an extension of the filing deadline must be made in advance, in writing, to Bureau of Health Plan Policy, Hospital Unit, 30 E. Broad St, 27th Floor, Columbus OH 43215-3414.

#### AMENDED FILINGS

Amended HCFA 2552-96 reports filed by hospitals with the Medicare intermediary must also be filed with ODJFS. No amendments to the JFS 02930 [Formerly ODHS 2930] will be accepted later than 30 days after the hospital's receipt of the audited interim settlement. Amendments received within 30 days after ODJFS' release of the audited interim settlement will not be considered unless they reflect a change in total reimbursement of at least \$5,000.00.

#### CHANGES

\*\*\* Note Change in mailing date from November 29, 2002 to December 2, 2002.

Additional instructions are included on Schedule F which are not effective for this year's cost report.

A signed certification sheet must be submitted with ANY revisions to the original filed cost report.

You must download Borland Database Engine from the web site in order to run the cost report software.

If you received UPL payments in January, February, and/or August 2002 for discharges during this reporting period, they must be included on Schedule H, Section I, line 5, column 1.

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SCHEDULE A

MISCELLANEOUS REVENUES

Note - Throughout the JFS 02930 [Formerly ODHS 2930] cost report instructions "Worksheet" refers to Medicare's HCFA 2552-96 and "Schedule" refers to the JFS 02930 [Formerly ODHS 2930].

Lines 1 - 19 - Enter all amounts included on Worksheet G-2 which are not included on the Worksheet C, column 8. Examples may be; Home Health, Hospice, Organ Acquisition, Professional Fees (detailed by cost center), etc.

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## SCHEDULE B

## COST DISTRIBUTION

Column 1

Lines 25-34, 37-97, and 100 - Enter total cost figures from Worksheet C, Part I, column 5 for each revenue center. **Note: Report costs for Organ Acquisition, Hospice, and Home Health Agency from Worksheet B, part I, column 27.**

Line 100 - Enter Observation Bed costs only if these costs are included both on line 25 and on line 62.

Column 2

Lines 25-34 and 37-97 - Enter all Interns and Residents costs that were removed from total cost reported on Worksheet B part I, column 26.

Column 3

Lines 25 - 97 - Enter the total of columns 1 and 2.

Column 4

For any revenue center that has costs but no corresponding charges, enter a charge of one dollar (\$1.00).

Lines 25-97 - Record total charges from Worksheet C, part I, column 8.

Line 100 - Enter one dollar (\$1.00) if an amount is entered in column 3, line 100.

Column 5

Lines 25-34, 37-97, and 100 - Divide each line amount in column 3 by the corresponding line amount in column 4 and enter the result rounded to six decimal places.

Column 6

Lines 25-34 and 37-97 - Enter the total allowable inpatient charges from Worksheet C, part I, column 6 for each revenue center. (**Note: Subprovider services reimbursed on a cost basis by Medicare but reimbursed by Medicaid on the DRG system must be included in this column; i.e., Distinct Part Psychiatric services. Do not enter data for those revenue centers not eligible for cost reimbursement or DRG payment, e.g. Home Health Agency, SNF, Hospice, Ambulance).**)

Line 100 - If Observation Bed costs are reported on line 62 and included in line 25, enter one dollar (\$1.00).

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## SCHEDULE B

## COST DISTRIBUTION

Column 7

Lines 25-34, 37-97, and 100 - Multiply the charges in column 6 by the corresponding ratio in column 5. Enter the result rounded to the nearest dollar.

Column 8

Lines 25-34 and 37-97 - Enter the total allowable outpatient charges from Worksheet C, part I, column 7 for each revenue center. Do not include amounts for those revenue centers previously not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.

Column 9

Lines 25-34 and 37-97 - Multiply the charges in column 8 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

Column 10

Lines 25-34 and 37-97 - Enter charges for revenue centers that are not eligible for cost reimbursement, i.e., Outpatient Laboratory, S.N.F. Ancillary, Hospice, Home Health Agency, and Ambulance.

Column 11

Lines 25-34 and 37-97 - Multiply the charges in column 10 by the corresponding ratio in column 5 and enter the result rounded to the nearest dollar.

Columns 1-11

Line 35 - Enter the total of lines 25 through 34.

Line 98 - Enter the total of lines 37 through 97.

Line 99 - Enter the total of lines 35 and 98.

Line 101 - Enter the total of line 99 less line 100.

(Line 101, Col. 4 must equal the sum of cols. 6,8,&10.)  
Be sure to foot and cross-foot all columns.

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