

SCHEDULE C

CALCULATION OF ROUTINE COSTS

Column 1 - Transfer amounts from Schedule B, column 7, lines 25-33 to the appropriate lines. Enter the sum of lines 25-33 on line 35.

Column 2 - Swing Beds - Transfer to line 25 the amount on Worksheet D-1, part I, line 26 as negative amounts. Enter the sum of lines 25-33 on line 35.

Column 3 - For each line enter the sum of columns 1 and 2. Enter the sum of lines 25-33 on line 35.

Column 4 - Enter the total days from Worksheet S-3, part I, column 6 to the appropriate lines. If there are Observation Bed days reported on Worksheet S-3, line 26, column 6, include these days in Adult & Pediatric, line 25. Do not include swing bed days. Enter the sum of lines 25-33 on line 35.

Column 5 - Divide each line amount in column 3 by the corresponding days in column 4 for lines 25-33 and enter the result rounded to two decimal places.

Column 6 - For each revenue center, enter the number of covered days of service rendered to Title XIX patients discharged during the reporting period. Do not include Observation Bed days or non-covered days (e.g., swing bed). Include transplant services that are paid on a DRG basis. (Do not include transplant services paid on a reasonable cost basis). Enter the sum of lines 25-33 on line 35.

Column 7 - For each revenue center, multiply the per diem calculated in column 5 by the XIX days reported in column 6 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

Column 8 - For each revenue center, enter the number of covered days of service rendered to Title V patients discharged during the reporting period. Do not include Observation Bed days or non-covered days. Enter the sum of lines 25-33 on line 35.

Column 9 - For each revenue center, multiply the per diem calculated in column 5 by the Title V days reported in column 8 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

Column 10 - For each revenue center, enter the number of covered days of service rendered to Title XIX transplant patients discharged during the reporting period. Include only transplant services paid on a reasonable cost basis. Do not include Observation Bed days, non-covered days, or transplant services paid by DRG. Enter the sum of lines 25-33 on line 35.

Column 11 - For each revenue center, multiply the per diem calculated in column 5 by the Title XIX transplant days reported in column 10 and enter the result rounded to the nearest dollar. Enter the sum of lines 25-33 on line 35.

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SCHEDULE C-1

DISCHARGE STATISTICS

As defined in Ohio Administrative Code, rule 5101:3-2-02 (B)(16):

A patient is said to be "discharged" when he or she:

- (a) Is formally released from a hospital
- (b) Dies while hospitalized
- (c) Is discharged, within the same hospital, from an acute care bed and admitted to a bed in a psychiatric unit distinct part as described in paragraph(B)(8) of this rule or is discharged within the same hospital, from a bed in a psychiatric unit distinct part to an acute care bed;
- (d) Signs self out against medical advice (AMA).

The discharges reported on this schedule should also include the number of patients transferred to other facilities.

SECTION I

Column 1 - Enter, from Worksheet S-3, part I, column 15, the number of discharges for each revenue center. Enter the sum of lines 36-39 on line 40.

Columns 2-4 - Enter the number of discharges from the facility for program patients. Title XIX services are classified by various rate years. Your fiscal year may not include every category. Only report discharges into the category that corresponds with your fiscal year. Enter the sum of each column on line 40. Include in columns 2 and 3 any discharges for transplant services that are paid on a DRG basis. Any transplant services that are not reimbursed on a DRG basis should be reported in column 5.

Column 2-4, line 41. Enter your capital add-on rate for the periods for which you reported discharges.

SECTION II

Line 42 - Enter as a sum, the number of beds on Worksheet S-3, part I, column 1, lines 12 and 14.

Line 43 - Enter as a sum, the net number of interns and residents in an approved teaching program on Worksheet S-3, part I, column 9, lines 12, and 14.

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SCHEDULE D

TITLE XIX COST CALCULATIONS

Column 1 - Enter the ratio from Schedule B, column 5, for each revenue center on the corresponding line.

Column 2

Lines 25-33 and 37-97 - Enter the charges for covered Title XIX inpatient services rendered during the reporting period. Include transplant services that are reimbursed on a DRG basis.

Column 3

Lines 25-33 - Transfer the cost amounts from Schedule C, column 7, lines 25 to 33.

Lines 37-97 - Multiply the charges in column 2 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 4

Lines 25-33 - Enter charges for covered outpatient services only if outpatient charges are also reported on Schedule B.

Lines 37-97 - Enter the charges for covered outpatient services. Do not include charges for Outpatient Laboratory Services, or any services which are not cost settled, (e.g., Pregnancy services).

Column 5

Lines 25-33 and 37-97 - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 6

Lines 41-44 and 70-97 - Enter the charges for Outpatient Laboratory Services.

Column 7

Lines 41-44 and 70-97 - Multiply the charges in column 6 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Column 8

Lines 25-33 and 37-97 - Report only allowable charges for transplant services that are reimbursed on a reasonable cost basis during the reporting period.

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SCHEDULE D

TITLE XIX COST CALCULATIONS

Column 9

Lines 25-33 - Transfer the cost amounts from Schedule C, column 11, lines 25-33.

Lines 37-97 - Multiply the charges in column 8 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Columns 2-5 and 8-9

Line 35 - Enter the total of lines 25 through 33.

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

Line 101 - Enter the total of lines 35 and 98.

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SCHEDULE D-1

TITLE V COST CALCULATIONS

Column 1

Lines 25-33 and 37-97 - Transfer total cost amounts from Schedule B, column 3, to the corresponding lines.

Column 2

Lines 25-33 and 37-97 - Enter the amount of cost associated with combined billing of provider based physician professional services as reported on Worksheets A-8 and A-8-2, column 4.

Column 3

Lines 25-33 and 37-97 - Enter the sum of columns 1 and 2.

Column 4

Lines 25-33 and 37-97 - Transfer the total charge amounts from Schedule B, column 4, to the corresponding lines.

Column 5

Lines 25-33 and 37-97 - Enter the amount of charges associated with combined billing of provider based physician professional services that are associated with the costs reported in column 2.

Column 6

Lines 25-33 and 37-97 - Enter the sum of columns 4 and 5.

Column 7

Lines 25-33 and 37-97 - Divide column 3 by column 6 and enter the resulting ratio, rounded to six decimal places, for each cost center.

Column 8

Lines 25-33 and 37-97 - Enter the charges for covered inpatient Title V services rendered during the cost reporting period.

Column 9

Lines 25-33 - Transfer the cost amounts from Schedule C, column 9.

Lines 37-97 - Multiply the charges in column 8 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

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SCHEDULE D-1

TITLE V COST CALCULATIONS

Column 10

Lines 25-33 and 37-97 - Enter the charges (including Outpatient Laboratory and Radiology services for covered outpatient Title V services) rendered during the reporting period.

Column 11

Lines 25-33 and 37-97 - Multiply the charges in column 10 by the corresponding ratio in column 7. Enter the result rounded to the nearest dollar.

Columns 1-11

Line 35 - Enter the total of lines 25 through 33.

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

Line 101 - Enter the total of lines 35 and 98.

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SCHEDULE E

UTILIZATION REVIEW COSTS AND MEDICAL EDUCATION COSTS

MEDICAL EDUCATION COSTS

- Line 1 - Enter the amount from Worksheet B, part I, column 20, line 95.
Line 2 - Enter the amount from Worksheet B, part I, column 21, line 95.
Line 3 - Enter the amount from Worksheet B, part I, columns 22 and 23, line 95.
Line 4 - Enter the amount from Worksheet B, part I, column 24, line 95.
Line 5 - Enter the total of lines 1 through 4.

XIX OUTPATIENT LAB PAYMENTS

- Line 6 - Enter the total Title XIX Outpatient Lab payments received that relate to charges reported on Schedule D, column 6, line 44.

NET PATIENT REVENUES

- Line 7 - Enter the Net Patient Revenue amount from Worksheet G-3 line 3.

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**SCHEDULE F
HOSPITAL CARE ASSURANCE UNCOMPENSATED CARE**

**OUT-OF-STATE HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.
OHIO ACUTE CARE HOSPITALS SHOULD COMPLETE SECTION I
PSYCHIATRIC HOSPITALS SHOULD COMPLETE SECTION II**

SECTION I (UNCOMPENSATED CARE FOR ACUTE CARE HOSPITALS)

INDEPENDENT THIRD PARTY VALIDATION OF SCHEDULE F DATA

Effective for Medicaid Cost Reports filed for cost reporting periods ending in State Fiscal Year (SFY) 2003, and each cost reporting period thereafter, each hospital, shall be required to have independent party, external to the hospital, verify the data reported on Schedule F. The external reviewer shall at a minimum perform the data verification based on a set procedures as follows.

1. Verify that patient logs are maintained for the following categories of patients:
 - Disability Assistance inpatient charges, with insurance
 - Uncompensated care inpatient charges < 100% federal poverty income limits (FPL), with insurance
 - Disability Assistance outpatient charges, with insurance
 - Uncompensated care outpatient charges < 100% FPL, with insurance
 - Disability Assistance inpatient charges, with no insurance
 - Uncompensated care < 100% FPL, inpatient charges, with no insurance
 - Uncompensated care > 100% FPL, inpatient charges, with no insurance
 - Disability Assistance outpatient charges, with no insurance
 - Uncompensated care < 100% FPL, outpatient charges, with no insurance
 - Uncompensated care > 100% FPL, outpatient charges, with no insurance

2. Verify that the Hospital's patient logs include a date-of-service. Verify that the service dates for accounts with Disability Assistance coverage or family income < 100% FPL are recorded in the cost report period in which they occurred, and that the write-off dates for accounts with family incomes >100% FPL, are recorded in the cost report period in which they were written-off.

3. Verify that the supporting patient log totals for the data elements listed below agree to each data element on the Hospital's JFS 02930 Schedule F. If any of the elements do not match, return the patient logs to Hospital for correction.
 - Column 1, Line 8 - Disability Assistance inpatient charges, with insurance
 - Column 1, Line 9 - Uncompensated care inpatient charges < 100% FPL, with insurance
 - Column 1, Line 12 - Disability Assistance, outpatient charges, with insurance
 - Column 1, Line 13 - Uncompensated care, outpatient charges, < 100% FPL, with insurance
 - Column 2, Line 8 - Disability Assistance, inpatient charges, with no insurance
 - Column 2, Line 9 - Uncompensated care, < 100% FPL, inpatient charges, with no insurance
 - Column 2, Line 10 - Uncompensated care, > 100% FPL, inpatient charges, with no insurance
 - Column 2, Line 12 - Disability Assistance outpatient charges, with no insurance
 - Column 2, Line 13 - Uncompensated care, < 100% FPL, outpatient charges, with no insurance
 - Column 2, Line 14 - Uncompensated care, > 100% FPL, outpatient charges, with no insurance.

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4. Verify the mathematical accuracy of Hospital's logs, by using at least the methodologies described below. If the logs were totaled manually, request adding machine tapes and match a sample of 10 entries on two of the tapes to the corresponding entries on the patient logs. If the logs were totaled with the use of an electronic spreadsheet, verify the accuracy of the formula(s) used. If the log entries were taken directly from the hospital's mainframe computer system, select one of the categories in Step 3 and tally the entries. If the logs do not foot according to any of the above alternatives, return the logs, and, if appropriate, the tapes to Hospital for correction.
5. From the hospital logs, select a random sample of entries from each of the ten data elements listed in Step 3, and verify the appropriateness of the write-off. The appropriateness of the write-off for each account selected shall be determined in accordance with Ohio Administrative Code (OAC) 5101:2-7-07.17 and the hospital's policies regarding the documentation of applicants' incomes.

The size of the required sample will vary according to which of three tiers the Hospital is placed in, using data from the current cost reporting period:

If the hospital reports total uncompensated care charges for patients without insurance that is less than \$5.0 million, the size of the sample shall be at a minimum, 32 accounts: four in each of the six data categories identified in Step 3 for patients with no insurance and two in each of the categories for patients with insurance.

If the hospital reports total uncompensated care charges for patients without insurance that is greater than \$5.0 million but less than \$10.0 million, the size of the sample shall be at a minimum, 64 accounts: eight in each of the six data categories identified in Step 3 for patients with no insurance and four in each of the categories for patients with insurance.

If the hospital reports total uncompensated care charges for patients without insurance that is greater than \$10.0 million, the size of the sample shall be at a minimum, 96 accounts: 12 in each of the six data categories identified in Step 3 for patients with no insurance and six in each of the categories for patients with insurance.

6. Obtain itemized statements from the Hospital for each of the patient accounts identified in the random selection of data elements identified in Step 5. Match the itemized statement to its corresponding entry in Hospital's log. Verify that patient accounts were correctly logged and entered in Schedule F, based on insurance status.

From the itemized statement, verify the patient's name, the date(s) of service, and whether the account is inpatient or outpatient and corresponds with the log entry. Subtract from the itemized statement any charges for services that can not be counted as "basic, hospital level" as described in OAC 5101:2-7-07.17 and OAC 5101:3-2-02, Appendix A. Verify that the sum of any subtraction of non-hospital level charges matches or does not exceed the entry for net charges in Hospital's log.

7. Obtain a copy of the Hospital's internal policy outlining its procedures for documenting applications for HCAP qualifying charity care or write-off.
8. Obtain copies of the documentation the Hospital used to determine eligibility for each of the patient accounts identified in the random selection of data elements identified in Step 5. Verify that the hospital's documentation practices are supported by its policy statement, obtained in Step 7, and are in accordance with OAC 5101:3-2-07.17.

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- 9. From the eligibility documentation outlined in Step 8, verify that the patients were residents of Ohio, and not eligible for Medicaid according to OAC 5101:2-7-07.17. Verify that the patient accounts logged as eligible for Disability Assistance (DA) were in fact eligible for DA on the date(s) of service. For accounts of patients <100 % FPL, verify that Hospital used the appropriate Federal Poverty Income Guidelines that were in effect for the date(s) of service, and verify that the patient's income and family size on the date(s) of service were correctly calculated according OAC 5101:2-7-07.17.
- 10. Request a list of pending-Medicaid accounts from Hospital. Verify that no accounts that have been approved for Medicaid were included in any log or Schedule F entry. If any Medicaid eligible accounts are included, ask the Hospital to remove all Medicaid eligible accounts from the logs and Schedule F.

The external reviewer shall issue a review report to the hospital, that includes any required corrective action on the part of the hospital.

External Data Validation Report

Each hospital shall retain all Schedule F data validation review reports for every cost report year, for a period of three years, and shall make such reports available to the department upon request, within three business days of such request.

GENERAL INSTRUCTIONS (APPLIES TO ALL OF SECTION I):

Only discharges/visits and charges for hospital services may be included in Schedule F. Include only "Basic, medically necessary hospital level services" which are considered services in Appendix A of rule 5101:3-2-02 of the Ohio Administrative Code. Do not include charges related to physicians' services, transportation services, or take-home pharmacy items, and do not include visits to free standing clinics or surgery centers that are not hospital based. Do not include any portion of a patient account for a Medicaid recipient, regardless of whether the recipient is enrolled in an HMO or Medicaid fee-for-service. Do not include discharge/visits and charges that have been written off as Medicare bad debts.

Report uncompensated care information for patients **with insurance** in Column 1. Report uncompensated care information for patients **without insurance** in Column 2. Schedule F does not include a column for reporting total uncompensated care; it will be calculated by the department. Include any charges, inpatient discharges, and outpatient visits for patients eligible for "Hill-Burton" or covered by a local levy fund. Do not consider any Hill-Burton write-off or any payment by a local health care levy to be "insurance." Exclude any contractual adjustments and payments you have received or reasonably expect to receive from these patients or their insurers.

In both Column 1 and 2 the amount reported in lines 8 through 15 must equal the patients' gross charges, minus any contractual adjustments, and minus any payments you have either received or reasonably expect to receive from these patients or their insurers.

The data on uncompensated care for people on Disability Assistance in lines 8 and 12, and the data on uncompensated care for patients with family incomes below federal poverty guidelines in lines 9 and 13, may only include inpatient and outpatient accounts with discharge/visit dates that fall within your hospital's fiscal year. You must split-bill any outpatient accounts which cross these dates. Uncompensated care for patients with family incomes above federal poverty income guidelines may be included in lines 10 and 14 regardless of the service dates, so

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