

SCHEDULE I

TITLE XIX HMO COST CALCULATIONS

OUT-OF-STATE HOSPITALS SHOULD NOT COMPLETE THIS SCHEDULE.

Column 1

Lines 25-33 and 37-97 - Enter the ratio from Schedule B, column 5 for each revenue center on the corresponding lines.

Column 2

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

Column 3

Lines 25-33 and 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, 37-40, and 45-97 - Enter the charges for Title XIX covered outpatient services. Do not include charges for Outpatient Laboratory Services.

Column 5

Lines 25-33, 37-40, and 45-97 - Multiply the charges in column 4 by the corresponding ratio in column 1. Enter the result rounded to the nearest dollar.

Columns 2-5

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.

Line 103, column 1 - Enter the Total XIX inpatient HMO days.
Line 103, column 2 - Enter the Total XIX outpatient HMO visits.

TN No. 03-007

APPROVAL DATE

JUN 2003

SUPERSEDES

TN No. 00-008EFFECTIVE DATE 3/27/03

**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
HOSPITAL COST REPORT
STATE FISCAL YEAR 2002
CERTIFICATION BY OFFICER OF HOSPITAL**

In accordance with current Medicaid regulations (42CFR, 455.18, 455.19), all cost reports must contain the following:

This is to certify that the foregoing information is true, accurate, and complete.
I understand that payment of this Medicaid claim will be from Federal and State funds,
and that any falsification, or concealment of a material fact, may be prosecuted under
Federal and State laws.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report supporting schedules prepared for:

Provider Name	Medicaid Provider Number
Street Address	Federal I.D. Number
City, State, and Zip Code	Medicare Provider Number(s)

for the cost reporting period beginning _____ and ending _____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions and regulations, except as noted.

Signature of Officer or Administrator of Provider(s)	Date of Signature
Print or Type Name	Title

Name of Individual Report Was Prepared By	Title
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Name of Person to Contact Regarding Report	Title
Telephone Number (Include Area Code)	

TN No. 03-007 APPROVAL DATE JUL 1 2003
SUPERSEDES
TN No. 00-008 EFFECTIVE DATE 03/27/03

**SFY 2002 INPATIENT
BILLING CODE ALLOCATION**

		UB-92 Revenue Center Codes
25.	Adult & Pediatric	001, 100, 110-113, 116, 117, 119, 120-123, 126, 127, 129, 130-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169, 206, 214, 220, 221, 224, 229, 230, 232, 239, 240, 249
25a.	Distinct Part Psychiatric	114, 124, 134, 154, 100
25b.	Distinct Part Rehabilitation	118, 128, 138, 158
26.	Intensive Care	200, 202-204, 208, 209, 233
27.	Coronary Care	210-213, 219, 234
28.	Burn Unit	207
29.	Surgical Intensive Care	201
30.	Other Special Care	*
31.	Nursery Intensive Care	174
33.	Nursery	170-173, 179, 231
37.	Operating Room	360-362, 367, 369,
37a.	Ambulatory Surgery	490, 499
37b.	Cast Room	700, 709
37c.	Treatment or Observation Room	760, 769
38.	Recovery Room	710, 719
39.	Delivery & Labor Room	720-724, 729
40.	Anesthesiology	370-372, 379
41.	Radiology - Diagnostic	320-324, 329, 400, 401, 403, 409, 610-612, 619, 790, 799, 920
41a.	CAT Scan	350-352, 359
41b.	Ultrasound	402
41c.	PET Scan	404
42.	Radiology - Therapeutic	330-333, 335, 339
43.	Radioisotope / Nuclear Medicine	340-342, 349
44.	Laboratory	300-302, 304-307, 309, 310-312, 314, 319, 921, 923-925, 929
44a.	Oncology	280, 289
46.	Whole Blood & Blood Components	380-387, 389
47.	Blood Processing, Storing & Transfusion	390, 391, 399
48.	Intravenous Therapy	260-264, 269
49.	Respiratory Therapy	410, 412, 413, 419
49a.	Pulmonary Function	460, 469
50.	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 949
50a.	Cardiac Rehab	943
51.	Occupational Therapy	430-434, 439
52.	Speech & Hearing Services	440-444, 449
52a.	Audiology	470-472, 479
53.	Electrocardiology	480, 482, 483, 489, 730-732, 739
53a.	Cardiac Catheterization	481
54.	Electroencephalography	740, 749
55.	Medical Supplies	270-272, 274-276, 278, 279, 291, 621-623
56.	Pharmacy	250-252, 254, 255, 257-259, 634, 635
57.	Renal Dialysis	800-804, 809, 880-881, 889
58.	Organ Acquisition	810-812, 814-817, 819
59.	Psychiatric/Psychological Services	900, 909, 910, 914-916, 918-919
60.	Clinic	510-517, 519
61.	Emergency	450, 456, 459
62.	Observation Beds	*
69.	Gastrointestinal Services	750, 759
70.		*
71.		*
72.		*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.

Billing codes should be allocated into revenue centers as indicated above. Any deviation from the above must be designated above to indicate where the billing codes were allocated, and why they were allocated differently than requested.

Do not include observation bed costs and charges reported on line 62 of the JFS 2930 and HCFA 2552-96 in revenue center 37b.

If one revenue center code is applicable to more than one revenue center, please show which revenue centers it was allocated to on the following page

* Please list the revenue center codes allocated to these revenue centers.

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**SFY 2002 OUTPATIENT
BILLING CODE ALLOCATION**

		UB-92 Revenue Center Codes
25.	Adult & Pediatric	001, 110-113, 116, 117, 119, 120-123, 126, 127, 129, 130-133, 136, 137, 139, 150-153, 156, 157, 159, 160, 164, 169
25a.	Distinct Part Psychiatric	114, 124, 134, 154, 100
25b.	Distinct Part Rehabilitation	118, 128, 138, 158
26.	Intensive Care	
27.	Coronary Care	
28.	Burn Unit	
29.	Surgical Intensive Care	
30.	Other Special Care	
31.	Nursery Intensive Care	
33.	Nursery	170, 171, 179
37.	Operating Room	360, 361, 369
37a.	Ambulatory Surgery	490, 499
37b.	Cast Room	700, 709
37c.	Treatment or Observation Room	760, 769
38.	Recovery Room	710, 719
39.	Delivery & Labor Room	720-724, 729
40.	Anesthesiology	370-372, 379
41.	Radiology - Diagnostic	320-324, 329, 400, 401, 403, 409, 610-612, 619, 790, 799, 920
41a.	CAT Scan	350-352, 359
41b.	Ultrasound	402
41c.	PET Scan	404
42.	Radiology - Therapeutic	330-333, 335, 339
43.	Radioisotope / Nuclear Medicine	340-342, 349
44.	Laboratory	300-302, 304-307, 309, 310-312, 314, 319, 921, 923-925, 929
44a.	Oncology	280, 289
46.	Whole Blood & Blood Components	380-387, 389
47.	Blood Processing, Storing & Transfusion	390, 391, 399
48.	Intravenous Therapy	260-264, 269
49.	Respiratory Therapy	410, 412, 413, 419
49a.	Pulmonary Function	460, 469
50.	Physical Therapy	420-424, 429, 530, 531, 539, 922, 940, 942, 945, 949
50a.	Cardiac Rehab	943
51.	Occupational Therapy	430-434, 439
52.	Speech & Hearing Services	440-444, 449
52a.	Audiology	470-472, 479
53.	Electrocardiology	480, 482, 483, 489, 730-732, 739
53a.	Cardiac Catheterization	481
54.	Electroencephalography	740, 749
55.	Medical Supplies	270-272, 276, 278, 279, 621- 623
56.	Pharmacy	250-252, 254, 255, 258, 259, 634, 635
57.	Renal Dialysis	820, 821, 829, 830, 831, 839, 840, 841, 849-851, 859, 880, 881, 889
58.	Organ Acquisition	
59.	Psychiatric/Psychological Services	900, 909, 910, 914-916, 918-919, 944
60.	Clinic	510-517, 519
61.	Emergency	450, 456, 459
62.	Observation Beds	*
69.	Gastrointestinal Services	750, 759
70.		*
71.		*
72.		*

Please refer to OAC 5101:3-2-02 for a list of inpatient and outpatient covered services.

Follow the same procedures as outlined on the Inpatient Billing Code Allocation Sheet

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 SUPERSEDES
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Schedule A

RECONCILIATION OF PATIENT REVENUES

Name of Hospital	Provider Number	Reporting Period
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	1 Inpatient	2 Outpatient	3 Total
1. Skilled Nursing Facility			
2. Observation Beds			
3. Home Health Agency			
4. Home Dialysis			
5. Meals on Wheels			
6. Professional Fees (SEE NOTE)			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
18.			
19.			

Note: PLEASE LIST PROFESSIONAL FEES BY SPECIFIC COST CENTER

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TOTAL FACILITY COST DISTRIBUTION

Name of Hospital		Provider Number					Reporting Period					
		1	2	3	4	5	6	7	8	9	10	11
		Costs	Int & Res Costs	Total Costs	Total Charges	Ratio	Inpatient Charges	Inpatient Costs	Outpatient Charges	Outpatient Costs	Non-Reimb Charges	Non-Reimb Costs
25.	Adult & Pediatric											
25a.	Distinct Part Psychiatric											
25b.	Distinct Part Rehabilitation											
26.	Intensive Care											
27.	Coronary Care											
28.	Burn Intensive Care Unit											
29.	Surgical Intensive Care											
30.	Other Special Care											
31.	Nursery Intensive Care											
33.	Nursery											
34.	SNF/ICF											
35.	Subtotal (lines 25-34)											
37.	Operating Room											
37a.	Ambulatory Surgery											
37b.	Cast Room											
37c.	Treatment or Observation Room											
38.	Recovery Room											
39.	Delivery & Labor Room											
40.	Anesthesiology											
41.	Radiology - Diagnostic											
41a.	CAT Scan											
41b.	Ultrasound											
41c.	PET Scan											
42.	Radiology - Therapeutic											
43.	Radioisotope / Nuclear Medicine											
44.	Laboratory											
45.	Oncology											
46.	Whole Blood & Blood Components											
47.	Blood Processing, Storing & Transfusion											
48.	Intravenous Therapy											
49.	Respiratory Therapy											
49a.	Pulmonary Function											

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TOTAL FACILITY COST DISTRIBUTION

Name of Hospital		Provider Number					Reporting Period					
		1	2	3	4	5	6	7	8	9	10	11
		Costs	Int & Res Costs	Total Costs	Total Charges	Ratio	Inpatient Charges	Inpatient Costs	Outpatient Charges	Outpatient Costs	Non-Reimb Charges	Non-Reimb Costs
50.	Physical Therapy											
50a.	Cardiac Rehabilitation											
51.	Occupational Therapy											
52.	Speech & Hearing Services											
52a.	Audiology											
53.	Electrocardiology											
53a.	Cardiac Catheterization											
54.	Electroencephalography											
55.	Medical Supplies											
56.	Pharmacy											
57.	Renal Dialysis											
58.	Organ Acquisition											
59.	Psychiatric/Psychological Services											
60.	Clinic											
61.	Emergency											
62.	Observation Beds											
63.	Home Program Dialysis											
64.	Ambulance											
65.	Durable Medical Equipment - Rented											
66.	Durable Medical Equipment - Sold											
67.	Home Health Agency											
68.	Hospice											
69.	Gastrointestinal Services											
70.												
71.												
72.												
73.												
74.												
98.	Subtotal (lines 37-97)											
99.	Total (lines 35+98)											
100.	Less Observation Beds	((((()	(
101.	Total (line 99-line 100)											

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CALCULATION OF ROUTINE COSTS

Name of Hospital		Provider Number				Reporting Period					
	1 Total Costs Of All Inpatients	2 Swing Bed Costs	3 Adjusted Total Col 1 + Col 2	4 Total Days	5 Per Diem Col 3 / Col 4	6 XIX Days	7 XIX Costs	8 V Days	9 V Costs	10 XIX Trans. Days	11 XIX Trans. Costs
25.	Adult & Pediatric										
25a.	Distinct Part Psychiatric										
25b.	Distinct Part Rehabilitation										
26.	Intensive Care										
27.	Coronary Care										
28.	Burn Intensive Care Unit										
29.	Surgical Intensive Care										
30.	Other Special Care										
31.	Nursery Intensive Care										
33.	Nursery										
35.	Total (lines 25-33)										

DISCHARGE STATISTICS

Schedule C-1

	1 Total	2 XIX PRIOR TO 01/01/02	3 XIX AFTER 12/31/01	4 TITLE V	5 TRANSPLANT
Section I					
36.	Adult & Pediatric				
37.	Distinct Part Psychiatric				
38.	Distinct Part Rehabilitation				
39.	Nursery				
40.	Total (lines 36-39)				
41.	Capital Add-on Rate				

Section II

42.	Number of Beds	
43.	Number Interns/Residents	

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EFFECTIVE DATE 3-27-03

TITLE XIX COST CALCULATIONS

Name of Hospital	Provider Number	Reporting Period
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	1	2	3	4	5	6	7	8	9
	Ratio	XIX Inpatient Charges	XIX Inpatient Costs	XIX Outpatient Charges	XIX Outpatient Costs	O/P Lab Charges	O/P Lab Costs	I/P Transplant Charges	I/P Transplant Costs
25. Adult & Pediatric									
25a. Distinct Part Psychiatric									
25b. Distinct Part Rehabilitation									
26. Intensive Care									
27. Coronary Care									
28. Burn Intensive Care Unit									
29. Surgical Intensive Care									
30. Other Special Care									
31. Nursery Intensive Care									
33. Nursery									
35. Subtotal (lines 25-33)									
37. Operating Room									
37a. Ambulatory Surgery									
37b. Cast Room									
37c. Treatment or Observation Room									
38. Recovery Room									
39. Delivery & Labor Room									
40. Anesthesiology									
41. Radiology - Diagnostic									
41a. CAT Scan									
41b. Ultrasound									
41c. PET Scan									
42. Radiology - Therapeutic									
43. Radioisotope / Nuclear Medicine									
44. Laboratory									
44a. Oncology									
46. Whole Blood & Blood Components									
47. Blood Processing, Storing & Transfusion									
48. Intravenous Therapy									
49. Respiratory Therapy									
49a. Pulmonary Function									
50. Physical Therapy									

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TITLE XIX COST CALCULATIONS

Name of Hospital	Provider Number	Reporting Period
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	1	2	3	4	5	6	7	8	9
	Ratio	XIX Inpatient Charges	XIX Inpatient Costs	XIX Outpatient Charges	XIX Outpatient Costs	O/P Lab Charges	O/P Lab Costs	I/P Transplant Charges	I/P Transplant Costs
50a. Cardiac Rehabilitation									
51. Occupational Therapy									
52. Speech & Hearing Services									
52a. Audiology									
53. Electrocardiology									
53a. Cardiac Catheterization									
54. Electroencephalography									
55. Medical Supplies									
56. Pharmacy									
57. Renal Dialysis									
58. Organ Acquisition									
59. Psychiatric/Psychological Services									
60. Clinic									
61. Emergency									
62. Observation Beds									
69. Gastrointestinal Services									
70.									
71.									
72.									
73.									
74.									
98. Subtotal (lines 37-97)									
101. Total									

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