



**Instructions for completing the Ohio Department of Developmental Disabilities (DODD) calendar year cost report for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID)**

## **GENERAL INSTRUCTIONS**

### **OVERVIEW**

As a condition of participation in the Title XIX Medicaid program, each ICF-IID shall file a Medicaid approved cost report (hereto referred to as cost report) with DODD. The cost report, including its supplements and attachments, must be filed within ninety days after the end of the reporting period. The cost report shall cover a calendar year. However, if the provider participated in the Medicaid program for less than twelve months during the calendar year, then the cost report shall cover the portion of a calendar year during which the ICF-IID participated in the Medicaid program.

If a provider begins operations on or after October 2, the cost report shall be filed in accordance with Section 5124.10 of the Ohio Revised Code (ORC).

For cost reporting purposes, ICFs-IID other than state-operated facilities shall use the Chart of Accounts for ICFs-IID as set forth in rule 5123:2-7-16 of the Ohio Administrative Code (OAC).

### **Filing Requirements**

The cost report must be filed electronically with the department on or before ninety days after the end of each facility's reporting period. Pursuant to ORC Section 5124.106, a provider whose cost report is filed after this date is subject to a reduction of their per diem rate in the amount of two dollars (\$2.00) per resident day, adjusted for inflation.

A provider may request a fourteen-day extension of the cost report filing deadline. Such requests must be made in writing, include an explanation of the reason the extension is being requested, and must demonstrate good cause in order to be granted. Requests should be made to the Division of Medicaid Development and Administration ICF Unit.

In the absence of a timely filed cost report, or request for filing extension, in addition to the application of the penalty described above, a provider will be notified by DODD of its failure to file a cost report and will be given thirty days to file the appropriate cost report and attachments. If a provider fails to submit a cost report within this time period, its Medicaid provider agreement will be terminated according to Section 5124.106 of the ORC.

## Reasonable Cost

Please read all instructions carefully before completing the cost report.

Reasonable cost takes into account direct, indirect, capital and other protected costs of providers of services, including normal standby costs. Departmental regulations regarding reasonable and allowable costs are contained in Chapter 5123:2-7 of the OAC. In addition, the following provisions establish guidelines and procedures to be used in determining reasonable costs for services rendered by ICFs-IID:

- Ohio Revised Code (ORC) and uncodified state law;
- DODD-promulgated regulations (OAC) codified in accordance with state law;
- Principles of reimbursement for provider costs with related policies described in the Centers for Medicare and Medicaid Services (CMS) Publication 15-1 ;
- Principles of reimbursement for provider costs with related policies described in the Code of Federal Regulations (CFR), Title 42, Part 413.

## Routine Services

OAC Rule 5123:2-7-11 lists covered services for all providers who serve ICF-IID residents. This rule delineates services reimbursed through the cost reporting mechanism of ICFs-IID, and the costs directly billed to Medicaid by service providers other than ICFs-IID.

## Accounting Basis

Except for county-operated facilities which may operate on a cash method of accounting, all providers are required to submit cost data on an accrual basis of accounting. County-operated facilities which utilize the cash method of accounting may submit cost data on a cash basis.

## Ohio Cost Report

The Ohio Medicaid ICF-IID cost report is designed to provide statistical data, financial data, and disclosure statements as required by federal and state rules. Exhibits to the cost report are part of the documents that may be required to file a complete cost report. Each exhibit to the cost report must be identified and cross-referenced to the appropriate schedule(s). Please refer to Attachment 3 for instruction on the use of exhibits.

## Cost Report Schedules

The provider must complete the information requested on each cost report schedule. Except for the cost report schedules and attachments listed below, responses such as "Not Applicable," "N/A," "Same as Above," "Available upon request," or "Available at the time of Audit," will result in the cost report being deemed incomplete or inadequate. Pursuant to section 5124.106 of the ORC, an incomplete or an inadequate cost report is subject to a rate reduction of \$2.00 per resident per day, adjusted for inflation as well as proposed termination of the provider agreement.

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## Cost Report Instructions

The following cost report instructions are in the order of schedule completion sequence.

- All expenses are to be rounded to the nearest dollar.
- All dates should contain eight digits and be formatted as follows: Month-Day-Year (MM-DD-YYYY).
- All date fields are denoted as From/Through or Beginning/Ending.

**Example:** January 1, (20CY) should be recorded as 010120CY (zero, one, zero, one, 20CY).

### 1. Schedule A, Page 1 of 2 - Identification and Statistical Data

#### Introduction

The various cost report types are explained below. Except for 4.1, annual cost report, all other cost report types must be accompanied with a cover letter explaining the reason for the filed cost report information. An explanation of the cost report types is as follows:

- |   |   |
|---|---|
| <b>4.1 - Year End</b>                   | Cost reports by providers with continued Medicaid participation having ending dates of December 31, pursuant to rule 5123:2-7-12 of the Administrative Code.  |
| <b>4.2 - New Facility</b>               | For facilities new to the medical assistance program, where the actual cost of operations are reported for the first three (3) full calendar months, which includes the date of certification, pursuant to rule 5123:2-7-12 of the Administrative Code.   |
| <b>4.3 - Change Of Operator</b>         | For the new operator's three (3) month cost report resulting agreement from a change of provider agreement pursuant to the OAC, which reports the actual cost of operations for the first three (3) full calendar months of Medicaid participation including the date of certification for the new operator, pursuant to rule 5123:2-7-12 of the Administrative Code.                           |
| <b>4.4 - Rate Reconsideration</b>       | For cost reports filed pursuant to rule 5123:2-7-12 of the Administrative Code where a change (extreme hardships) in the current fiscal year payment rate is requested.   |
| <b>4.5 - Final</b>                      | For the final cost report of a provider who has experienced a change of provider agreement or closure pursuant to rule 5123:2-7-12 of the Administrative Code.  |
| <b>4.6 - Amended</b>                    | For cost reports filed after the fiscal year rate setting, which corrects errors of the cost report used to establish the fiscal year rate, pursuant to rule 5123:2-7-12 of the Administrative Code.  |
| <b>4.8 – Downsizing/<br/>Conversion</b> | Optional cost report for providers who qualify based on ORC Section 5124.101, this cost report covers the first three (3) full calendar months beginning with the date on which the qualifying downsizing/conversion took place. In the case of a downsizing, both the downsized facility and new facility that opens as a result of the downsizing are eligible to file this cost report type. |

## **Facility Identification**

**Provider Name (DBA)** - Enter the "doing business as" (DBA) name of the facility as it appears on the Medicaid provider agreement.

**National Provider Identifier (NPI)** - Enter the NPI if available. Ohio ICFs-IID are not currently required to submit electronic claims for payment. Therefore DODD will not require ICFs-IID to obtain or submit NPIs at this time. However, if one is acquired, we encourage the ICF-IID to insert it in the cost report. Applying for an NPI does not replace any enrollment or credentialing processes with Medicaid.

**Medicaid Provider Number** - Enter the seven digit Medicaid provider number as it appears on the Medicaid provider agreement.

**Medicare Provider Number** - Enter the six digit Medicare provider number furnished by the Ohio Department of Health (ODH) or the CMS. Medicare numbers are assigned to each facility regardless of the facility's Medicare certification status. The Medicare number also appears on the Medicaid provider agreement.

**Complete Facility Address** - Enter the address of the facility. Include city and ZIP code where the facility is physically located.

**Federal ID Number** - Enter the Federal Tax Identification Number as it is reported to the United States Internal Revenue Service.

**ODH ID Number** - Enter the ODH 4-digit home number, also referred to by ODH as the "Fac ID" Number.

**County** - Enter the Ohio county in which the facility is physically located.

## **Period Covered by the Cost Report**

This is a twelve-month period ending December thirty-first unless another period has been designated by the DODD. New facilities, closed facilities, or exiting or entering operators as a result of a change of operator must indicate the time period of Medicaid participation.

## **Provider Legal Entity Identification**

Name and address of provider of services - Enter the legal business name for the provider of this facility as reported to the IRS for tax purposes and as it appears on the medicaid provider agreement, and furnish the address of this legal entity.

## **Type of Control of Provider**

Check the category that describes the form of business, nonprofit entity or government organization under which the facility is operated, which corresponds for non-government organizations with the way the operator legal entity is registered with the Ohio Secretary of State's office. If item 1.4, 2.6 or 3.6 Other [specify] is checked, the provider must identify that specific type of control. Descriptions for the "For Profit" control types are furnished below.

### **For Profit**

**Sole Proprietor** – Exclusively owned; Private; Owned by a private individual or corporation under a trademark or patent; Ownership – for profit. In a sole proprietorship the individual proprietor is subject to full liability (personal assets and business assets) resulting from business acts.

**Partnerships** – An association of two or more persons or entities that conducts a business for profit as co-owners. A partnership cannot exist beyond the lives of the partners. The partners are taxed as individuals and are personally liable for torts and contractual obligations. Active partners are subject to self-employment tax. Each partner is viewed as the other's agent and traditionally is jointly and severally liable for the tortuous acts of any one of the partners. A contract entered into by two or more persons in which each agrees to furnish a part of the capital and labor for a business enterprise and by which each shares in some fixed proportion in profits and losses.

**General Partnership** – A partnership in which each partner is liable for all partnership debts and obligations in full, regardless of the amount of the individual partner's capital contribution.

**Limited Partnership** – A partnership in which the business is managed by one or more general partners and is provided with capital by limited partners who do not participate in management but who share in profits and whose individual liability is limited to the amount of their respective capital contributions. A limited partnership is taxed like a partnership but has many of the liability protection aspects of a corporation. To form a limited partnership, a certificate of limited partnership must be executed and filed with the Secretary of State (Secretary of State prescribes the form required). The name of a limited partnership must include the words "Limited Partnership," "L.P.," "Limited," or "Ltd."

**Limited Liability Partnership** – a partnership formed under applicable state statute in which the partnership is liable as an entity for debts and obligations and the partners are not liable personally. This type of partnership must register with the Secretary of State as a limited liability partnership.

**Corporation** –An invisible, intangible, artificial creation of the law existing as a voluntary chartered association of individuals that has most of the rights and duties of natural persons but with perpetual existence and limited liability. Any person, singly or jointly with others, and without regard to residence, domicile or state of incorporation may form a corporation. A "person" includes any corporation, partnership, unincorporated society or association and two or more persons having a joint or common interest.

**Limited Liability Company** – An unincorporated company formed under applicable state statute whose members cannot be held liable for the acts, debts, or obligations of the company and that may elect to be taxed as a partnership. A limited liability company may be formed in Ohio by any person without regard to residence, domicile or state or organization. The entity is formed when one or more persons of their authorized representatives signs and files articles of organization with the Secretary of State. The name of the limited liability company must include the words "limited liability company," "LLC," "L.L.C.," "Ltd.," "Ltd," or "Limited." A "person" includes any natural person, corporation, partnership, limited partnership, trust, estate, association, limited liability company, any custodian, nominee, trustee, executor, administrator, or other fiduciary.

**Business Trust** – A business trust is created by a trust agreement and can only be created for specific purposes: To hold, manage, administer, control, invest, reinvest, and operate property; to operate business activities; to operate professional activities; to engage in any lawful act or activity for which business trusts may be formed per the ORC.

**Real Estate Investment Trust (REIT)** - means a trust created by an instrument, pursuant to common law or enabling legislation, under which any estate or interest in real property is held, managed, administered, controlled, invested, reinvested, or operated by a trustee or trustees for the benefit and profit of persons who are or may become the holders of transferable certificates of beneficial interest, issued pursuant to the provisions of the trust instrument, such transferability being either restricted or unrestricted, which trust intends to comply or has at any time complied or intended to comply with sections 856, 857, and 858 of the Internal Revenue Code of 1954, 68 A Stat. 3, 26 U.S.C. 1, as now or hereafter amended.

## Location of Entity, Organization or Incorporation

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

**Domestic** refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

**Foreign** refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio.

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

## Non-Profit

**Non-Profit Corporation** - A "nonprofit corporation" is a domestic or foreign corporation organized otherwise than for pecuniary gain or profit. A non-profit corporation can be either a "mutual benefit corporation" or a "public benefit corporation." A "public benefit corporation" is a corporation that is recognized as exempt from federal income taxation under 501(c)(3) of the "Internal Revenue Service Code of 1986," 100 Stat. 2085, 26 U.S.C. I, as amended, or is organized for a public or charitable purpose and, that upon dissolution, must distribute its assets to a public benefit corporation, the United State, a state or any political subdivision of a state, or a person that is recognized as exempt from federal income taxation under 501(c)(3) of the "Internal Revenue Code of 1986" as amended.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated in the state of Ohio, check the Domestic line.

**Domestic** refers to a business entity doing business in Ohio that was formed, incorporated, or organized in Ohio.

If the legal entity that serves as the facility's provider/operator was formed, organized, or incorporated outside the state of Ohio, check the Foreign line.

**Foreign** refers to a business entity doing business in Ohio that was formed, incorporated, or organized under the laws of another state or foreign country. Foreign corporations must be licensed to do business in Ohio. Foreign limited liability companies, foreign limited partnerships and foreign limited liability partnerships must be registered to transact business in Ohio

If the foreign line is checked, list the state or country where the legal entity was formed, organized, or incorporated on the **Location** line.

## Non-Federal Government

**State** – entity operated under the authority of the state.

**County** – entity operated under the authority of the county as a County Home, County Nursing Home, or District Home in accordance with the ORC.

**City** – entity operated under the authority of the city.

**City/County** – entity jointly operated under the authority of the city & county.

**County Board of DD** – entity operated by a county board of developmental disabilities.

## Care Setting

Indicate the care setting of the facility, in accordance with licensure standards filed with DODD, when applicable. Please check all that apply.

## Definitions

**Rehab Hospital Based** – serves an inpatient population of whom at least 75% require intensive rehabilitative services; has a preadmission screening procedure which determines whether the patient will benefit significantly from an intensive inpatient hospital program or assessment; and uses a coordinated multidisciplinary team approach in the rehabilitation of each inpatient. Inpatients using rehabilitative services usually have one or more of the following diagnoses: stroke, spinal cord injury, congenital deformity, major multiple trauma, femur fracture, brain injury, polyarthritis (including rheumatoid arthritis), neurological disorders and burns.

**General/Acute Hospital Based** – means a hospital which primarily functions to furnish the array of diagnostic and therapeutic services needed to provide care for a variety of medical conditions, including diagnostic x-ray, clinical laboratory, and operating room services.

**Home for the Aging** – Per the ORC, means a home that provides services as a residential care facility and a nursing home, except that the home (nursing home) provides its services only to individuals who are dependent on the services of others by reason of both age and physical or mental impairment.

**Continuing Care Retirement Center (CCRC)** – means a living setting which encompasses a continuum of care ranging from an apartment or lodging, meals, and maintenance services to total nursing home care. All services are provided on the premises of the continuing care retirement community and are provided based on the contract signed by the individual resident. The residents may or may not qualify for medicaid for nursing home care, based on the services covered by each resident's individually signed contract.

**Other Assisted Living/Nursing Home combination** – A facility that does not fit the description of a CCRC or a Home for the Aging, but has a nursing home as well as some other combination of assisted living or residential care facility services on the same campus.

**Religious Non-medical Health Care Institution (RNHCI)** - An institution in which health care is furnished under established religious tenets that prohibit conventional or unconventional medical care for the treatment of a beneficiary, and the sole reliance on these religious tenets for care and healing, as set forth in 42 CFR Part 403, Subpart G - Religious Nonmedical Health Care Institutions.

**Free Standing** – A facility that stands independent of attachment or support.

**Combined with Nursing Facility (NF), other recognized Medicaid ICF-IID and/or Medicaid Outlier Unit** -- A distinct part of a facility that is in the same building and/or shares the same license with a certified NF, or is in same building as a recognized separate provider of medicaid, such as a provider of outlier services (e.g., for pediatric residents or residents with traumatic brain injury), or for the outlier unit, is housed with a NF providing non-outlier services. [Note: A provider of ICF-IID outlier services holds an Ohio medicaid provider agreement addendum authorizing the provision of outlier services to a special population (e.g., pediatric subacute).]

**Name and Address of Owner of Real Estate** - Enter the name and address of the owner of the real estate where the facility is located. If the provider of services is the identical legal entity that owns the real estate, re-enter the provider's legal entity identification here.

## 2. Schedule A, Page 1 of 2, Statistical Data

### Lines 1 and 2: Licensed Beds:

Enter the total number of beds licensed by DODD in column 2. Enter the total number of beds licensed by ODH and certified by Medicaid in column 1. Temporary changes because of alterations, painting, etc. do not effect bed capacity.

### Line 3: Total Bed Days:

For column 1, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by DODD and certified by ODH during the reporting period. Take into account increases or decreases in the number of beds licensed and certified and the number of days elapsed since the increase or decrease in licensed and certified beds.

For column 2, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by DODD during the reporting period. Take into account increases or decreases in the number of beds licensed and the number of days elapsed since the increases or decreases.

### Line 4: Total Inpatient Days:

For column 1, obtain the answer from Schedule A-1, column 9, line 13. For column 2, enter the total number of inpatient days for the facility for all DODD licensed beds.

### Line 5: Percentage of Occupancy:

This amount is the proportion of total inpatient/resident days to total bed days during the reporting period. Obtain the answer by dividing line 4 by line 3.

### Line 6.1: Indirect Care Allowable Days:

For computing indirect care costs, DODD will not recognize an occupancy rate of less than 85%. If percentage of occupancy is 85% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 85%, enter 85% of the number of bed days stated on line 3 (See the OAC). For providers on the Medicaid program less than 12 months, also consult the OAC.

## **Lines 6.2: Capital Allowable Days:**

For computing property ownership costs, DODD will not recognize an occupancy rate of less than 95%. If percentage of occupancy is 95% or more, enter the number of inpatient days stated on line 4. If percentage of occupancy is less than 95%, enter 95% of the number of bed days stated on line 3 (See the OAC). For providers on the Medicaid program less than 12 months, also consult the OAC.

*\*\* Number of beds involved in the change refers only to those beds which were added, replaced, or removed.*

## **Schedule A, Page 2 of 2, Certification by Officer of Provider**

Chain organizations are generally defined as multiple providers owned, leased, or through any other device, controlled by a single organization. For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by for profit /proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

The controlling organization is known as the chain "home office." Typically, the chain "home office:"

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills, and
- Maintains and centrally controls individual provider cost reports and fiscal records.

All providers that are currently part of a chain organization or who are joining a chain organization must complete this section with information about the chain home office.

**A. Check Box** – If this section does not apply to this provider, check the box provided and skip to the certification section.

**B. Chain Home Office Information** – If there has been a change in the home office information since the previous cost reporting period, check "Change," and provide the effective date of the change.

Complete the appropriate fields in this section:

- Furnish the legal business name and tax identification number of the chain home office as reported to the IRS.
- Furnish the street address of the home office corporate headquarters. Do not give a P.O. Box or Drop Box address.

**C. Provider's Affiliation to the Chain Home Office** – If this section is being completed to report a change to the information previously reported about the provider's affiliation to the chain home office since the last cost reporting period, check "Change," and provide the effective date of the change.

Check all that apply to indicate how this provider is affiliated with the home office.

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.

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.

Reference Source: 09-05 FORM CMS 287-05 3901

### 3900. HOME OFFICE COSTS - CHAIN OPERATIONS

*For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care. (See CMS Pub. 15-I, chapter 10 for definitions of common ownership and control.)*

### 3. Schedule A-1, Summary of Inpatient Days

**Column 1:** Record the number of ODH-certified beds, by month. If the number of beds certified by ODH changed during the middle of any given month, then calculate a weighted average for that particular month rounded up to the next whole number.

**For example:**

March 1, 20CY - 12 certified beds

March 16, 20CY - 10 certified beds

**Calculation:** (15 days x 12 beds) + (16 days x 10 beds)  
divided by 31 days in month of March = 10.9677

Average Medicaid certified beds for March 20CY = 11

**Column 2:** Record the number of authorized ICF-IID and pending Medicaid patient days, by month

**Column 3, 4, and 5:** Record the total monthly reimbursable leave days for Medicaid residents [see OAC - coverage of medically necessary days and limited absences].

Report each necessary day and limited absence as 100% of an inpatient day.

**For Example:**

Column 3 Hospital Leave Days 60 (60 days x 100%)

Column 4 Therapeutic Leave Days 40 (40 days x 100%)

Column 5 Friends and Relatives Leave Days 10 (10 days x 100%)

**Column 6:** Total of columns 2, 3, 4, and 5. Carry the total on line 13, column 6 forward to Schedule A, line 7.

**Column 7, 8 and 9:** Record the number of inpatient days for non-Medicaid eligible residents, by month. Leave days should not be included in these columns but should be reported on Attachment 4.

**Column 10:** Record the number of inpatient days for all residents, by month. This column is the sum of columns 6 through 9.

The day of admission, but not the day of discharge, is an inpatient day. When a resident is admitted and discharged on the same day, this is counted as one inpatient day. Inpatient days include those leave days that

are reimbursable under the Ohio Medicaid program. Private leave days are not included as inpatient days. Carry the total on line 13, column 10 forward to Schedule A, line 4, column 1.

Pursuant to the OAC, reimbursement may be made to reserve a bed for not more than thirty days in any calendar year unless further prior approval is obtained for any combination of hospital stays or visits with friends or relatives or participation in therapeutic programs.

For ICFs-IID, reimbursement for medically necessary leave days is one hundred per cent (100%) of the facility's per diem rate.

#### **4. Trial Balance**

Cost/Revenue information and allocation ratios (as applicable) for most schedules contained in the cost report are entered directly into the Trial Balance in the ACR software. The Trial Balance covers data entry for Schedules B-1, B-2, C, D, E, and Attachment 1.

#### **5. Schedule A-2, Determination of Medicare Part B Costs to Offset:**

This schedule is designed to determine the amount of Medicare Part B revenue to offset on the cost report by cost center to comply with the OAC. This schedule is populated automatically in the Automated Cost Reporting software based on entries and total from other schedules.

#### **6. Schedule A-3, Summary of Costs**

Column 5: Calculate per diems for each cost category. This cost per diem is subject to change and does not reflect the payment to be made by Medicaid. This schedule is populated automatically in the Automated Cost Reporting software based on entries and total from other schedules

#### **7. Schedules B-1, B-2, C, and D (Columns 1-7)**

\*Note that these schedules are filled out in the ACR on the Trial Balance and fed to the appropriate lines based on account number.

Amounts paid to vendors for purchase of services must not be shown in columns designated "salary." Such amounts should be shown in the "other" column for the appropriate line item(s). If no specific line item exists, charge the cumulative expense to the "other" category and provide supporting documentation as exhibits with cross references to the applicable account number(s).

Column 1: Report wages for facility employees. Wages are to include wages for sick pay, vacation pay, other paid time off, as well as any other compensation paid to the employee.

Column 2: Report 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. Also report any appropriate non-wage expenses, including contract services and supplies.

Column 4: Report any increases or decreases of each line item. Any entries in this column which are not from Attachment 2 should be fully explained in accordance with the instructions on Attachment 3.

If no allocations are used, columns 6 and 7 need not be completed. If allocation is used, limit the precision to four places to the right of the decimal.

## 8. Schedule C-1, Administrators Compensation

A separate schedule must be completed for each person(s) claiming reimbursement as an administrator in this facility.

### Section A:

**Line 2:  
Work Experience** For this administrator, report the number of years of work experience in the health care field. Ten years' experience is the maximum allowance. Thus, for this category, if the administrator has ten or more years' experience in the health care field, then record ten years in this box.

**Line 3:  
Formal Education** For this administrator, report the number of years of formal education beyond high school. Six years formal education is the maximum allowance for this category. Thus, if the administrator has six or more years' formal education, then record six years in this box.

**Line 3.1:  
Baccalaureate Degree** For this administrator, record yes if the administrator has obtained a baccalaureate degree. If the administrator has not obtained a baccalaureate degree, then record no.

**Line 4:  
Other Duties** Record the total number of other duties not normally performed by this administrator. This administrator may claim up to four additional duties. If this administrator performed four or more extra duties, then report the maximum of four.

Include the following **other duties** in your count: accounting, maintenance, and housekeeping. If the administrator performed any other duties, please complete the "Other, specify" lines. For example, if the administrator performed laundry duties, then record as follows: Other, specify laundry.

Do not include any of the direct care duties listed below. If the administrator performed any of the twelve duties listed below then go to Schedule C-2. Complete Page 1 of Schedule C-2. If the administrator is an owner or relative of the owner, then complete Page 2 also.

- (a) Medical director
- (b) Director of nursing
- (c) Activities director
- (d) Registered nurse (RN)
- (e) Licensed practical nurse (LPN)
- (f) Psychologist
- (g) Respiratory therapist
- (h) Qualified Intellectual Disability Professional (QIDP)
- (i) Licensed social worker/counselor
- (j) Chaplain
- (k) Charge nurse; registered
- (l) Charge nurse; licensed practical

**Line 5:** Add 6% if the facility is in one of the following counties: Cuyahoga, Hamilton, Butler, Stark, Franklin, Lucas, Montgomery or Summit.  
**Geographic Location**

NOTE: The eight counties listed above reflect those counties projected to have the largest populations. This information is subject to change once the calendar year data becomes available.

**Line 6:** Add ten points if the administrator is also an owner.  
**Ownership Points**

**Line 7:** Total lines 1 through 6.

**Line 8:** Line 7 is not to exceed 150%.

### Section B:

For each administrator, complete the following:

- Beginning and ending dates of employment during the 20CY reporting period should be confined to periods of employment in 20CY only. For example, if the administrator was employed by the provider from March 1, 20CY through March 31, 20CY, then for the 20CY reporting period the record of employment dates is as follows: 03/01/20CY - 03/31/20CY.
- Hours and percentage of time worked weekly on site at the facility.
- Account number 7200 or account number 7310, as appropriate. All administrators compensated through the home office use account 7310. All other administrators use account 7200.
- Amount of compensation: Except for county facilities which operate on a cash basis, list all compensation actually accrued to employees who perform duties as the administrator. County facilities which operate on a cash basis should list all compensation actually paid to employees who perform duties as the administrator.
- If the administrator is an owner or relative of an owner, then complete Schedule C-2, Page 2 of 2. Do not complete Schedule C-2, Page 2 of 2 for a non-owner/administrator. Report the cost of all indirect care-related duties performed by administrator on Schedule C, line 26, account number 7200 or Schedule C, line 48, account number 7310, whichever is applicable.

The applicable Direct Care duties are:

- |                                    |   |
|------------------------------------|---|
| a) Medical Director;               | h) Qualified Intellectual Disability Professional (QIDP); |
| b) Director of Nursing;            | i) Licensed Social Worker/Counselor;                      |
| c) Activities Director;            | j) Chaplin;   |
| d) Registered Nurse (RN);          | k) Charge Nurse; Registered; and,                         |
| e) Licensed Practical Nurse (LPN); | l) Charge Nurse; Licensed Practical.                      |
| f) Psychologist;                   |   |
| g) Respiratory Therapist;          |   |

**Example:** An owner/administrator (or relative of owner) earned \$65,000 compensation performing duties as follows:

RN \$15,000; Administrator \$45,000; Laundry \$5,000; Total = \$65,000

Compensation may be reported as follows:

Schedule C-1 = \$50,000 - Administrator plus laundry compensation

Schedule B-2 = \$15,000 - RN compensation

Please note the reporting procedures are the same regardless of whether the administrator is an owner/administrator, or a relative of the owner.

Non-owner administrators will report their wages on Schedule C-1 (administrator and general wages) and, if it applies, Schedule B-2 (direct care wages, as stipulated in the direct care duties list above). Wages for non-owner/administrators are never reported on Schedule C-2.

## 9. Schedule C-2

### Page 1 of 2:

List all owners and/or relatives who received compensation from this provider. Also, complete the schedule if any administrator wages are reported on Schedule B-2 for the direct care duties. This applies regardless of whether the administrator is a non-owner/administrator, an owner/administrator, or a relative of the owner.

Specify the name of person(s) claiming compensation, position number (see below), relationship to owner(s), years of experience in this field, dates of employment in this reporting period, number of hours worked in facility during the week, as well as the corresponding percentage of time worked at this facility, account number, and amount claimed for each person listed on the cost report.

For purposes of completing Schedule C-2, the following relationships are considered related to the owner:

1. Husband and wife;
2. Natural parent, child, and sibling;
3. Adopted child and adoptive parent;
4. Stepparent, stepchild, stepbrother, stepsister;
5. Father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, and brother-in-law;
6. Grandparent and grandchild; and,
7. Foster parent, foster child, foster brother, or foster sister.

### Page 2 of 2:

Except for the non-owner administrators, for each individual identified above, list all the compensation received from other facilities participating in the Medicaid program (in Ohio and other states). Also, list any individual owning a 5% or more interest in this provider. Compensation claimed must be for necessary services and related to resident care. Services rendered and compensation claimed must be reasonable based upon the time spent in performing the duty, and reasonable for the duty being performed.

If Schedule C-2, Page 1 is completed for a non-owner administrator, then do not complete this page for the non-owner administrator. All other owners, relatives of owners, or owner/administrators identified on Page 1 must also be reported on Page 2 of Schedule C-2.

### **Position Numbers for Corporate Officers**

Select the four-digit position number that appropriately identifies the job duty of the corporate officer.

**Example:** Where there is a corporate president of a 50-bed facility, the four digit position number is: CP01 (C, P, zero, one).

#### **1. Corporate President Series (CP)**

CP01 - Corporate President 1 (1 - 99 beds)

CP02 - Corporate President 2 (100 - 199)

CP03 - Corporate President 3 (200 - 299)

CP04 - Corporate President 4 (300 - 599)

CP05 - Corporate President 5 (600 - 1199)

CP06 - Corporate President 6 (1200 +)

#### **2. Corporate Vice - President Series (CV)**

CV01 - Corporate Vice-President 1 (1 - 99 beds)

CV02 - Corporate Vice-President 2 (100 - 199)

CV03 - Corporate Vice-President 3 (200 - 299)

CV04 - Corporate Vice-President 4 (300 - 599)

CV05 - Corporate Vice-President 5 (600 - 1199)

CV06 - Corporate Vice-President 6 (1200 +)

#### **3. Corporate Treasurer Series (CT)**

CT01 - Corporate Treasurer 1 (1 - 99 beds)

CT02 - Corporate Treasurer 2 (100 - 199)

CT03 - Corporate Treasurer 3 (200 - 299)

CT04 - Corporate Treasurer 4 (300 - 599)

CT05 - Corporate Treasurer 5 (600 - 1199)

CT06 - Corporate Treasurer 6 (1200 +)

#### **4. Board Secretary Series (BS)**

BS01 - Corporate Board Secretary 1 (1 - 99 beds)

BS02 - Corporate Board Secretary 2 (100 - 199)

BS03 - Corporate Board Secretary 3 (200 - 299)

BS04 - Corporate Board Secretary 4 (300 - 599)

BS05 - Corporate Board Secretary 5 (600 - 1199)

BS06 - Corporate Board Secretary 6 (1200 +)

**Position Number for Owners/Relatives of Owner**

Select the five-digit position number, which appropriately identifies the job duty of the owner and/or relative of the owner. Please note that **WH** references the Wage and Hour Survey - Attachment 6 of the cost report.

Example: Where the owner served as medical director of the facility, the five-digit position number is: WH002 (W, H, zero, zero, two).

<b>WH Code</b>	<b>Title</b>	<b>Account</b>	<b>Schedule / Line</b>
WH001	Water and Sewage	6030	Schedule B-1, line 9
WH002	Medical Director	6100	Schedule B-2, line 1
WH003	Director of Nursing	6105	Schedule B-2, line 2
WH004	RN Charge Nurse	6110	Schedule B-2, line 3
WH005	LPN Charge Nurse	6115	Schedule B-2, line 4
WH006	Registered Nurse	6120	Schedule B-2, line 5
WH007	Licensed Practical Nurse	6125	Schedule B-2, line 6
WH008	Nurse Aides	6130	Schedule B-2, line 7
WH009	Activity Director	6135	Schedule B-2, line 8
WH010	Activity Staff	6140	Schedule B-2, line 9
WH012	Program Specialist	6150	Schedule B-2, line 10
WH013	Program Director	6155	Schedule B-2, line 11
WH015	Habilitation Supervisor	6165	Schedule B-2, line 12
WH016	Habilitation Staff	6170	Schedule B-2, line 13
WH017	Psychologist	6175	Schedule B-2, line 14
WH018	Psychology Assistant	6180	Schedule B-2, line 15
WH019	Respiratory Therapist	6185	Schedule B-2, line 16
WH020	Social Work/Counseling	6190	Schedule B-2, line 17
WH021	Social Services/Pastoral Care	6195	Schedule B-2, line 18
WH022	Qualified Mental Retardation Professional (QMRP)	6200	Schedule B-2, line 19
WH023	Quality Assurance	6205	Schedule B-2, line 20
WH024	Other Direct Care Salaries: Specify	6220	Schedule B-2, line 23
WH025	Home Office Costs/Direct Care: Salary	6230	Schedule B-2, line 24
WH030	Physical Therapist	6600	Schedule B-2, line 30
WH031	Physical Therapy Assistant	6605	Schedule B-2, line 31
WH032	Occupational Therapist	6610	Schedule B-2, line 32
WH033	Occupational Therapy Assistant	6615	Schedule B-2, line 33

<b>WH Code</b>	<b>Title</b>	<b>Account</b>	<b>Schedule / Line</b>
WH034	Speech Therapist	6620	Schedule B-2, line 34
WH035	Audiologist	6630	Schedule B-2, line 35
WH036	EAP Administrator-Direct Care	6535	Schedule B-2, line 40
WH037	Self-Funded Programs Administrator: Direct Care	6540	Schedule B-2, line 41
WH038	Staff Development-Direct Care	6550	Schedule B-2, line 42
WH039	Dietitian	7000	Schedule C, line 1
WH040	Food Service Supervisor	7005	Schedule C, line 2
WH041	Dietary Personnel	7015	Schedule C, line 3
WH042	EAP Administrator - Dietary	7075	Schedule C, line 15
WH043	Self-Funded Programs Administrator: Dietary	7080	Schedule C, line 16
WH044	Staff Development - Dietary	7090	Schedule C, line 17
WH045	Medical/Habilitation Records	7105	Schedule C, line 20
WH046	Pharmaceutical Consultant	7110	Schedule C, line 21
WH048	Other Administrative Personnel	7210	Schedule C, line 27
WH049	Security Services (Salary Only)	7230	Schedule C, line 31
WH050	Laundry/Housekeeping Supervisor	7240	Schedule C, line 34
WH051	Housekeeping	7245	Schedule C, line 35
WH052	Laundry and Linen	7250	Schedule C, line 36
WH053	Accounting	7265	Schedule C, line 39
WH054	Data Services (Salary Only)	7285	Schedule C, line 43
WH055	Other Indirect Care - Specify: (Salary)	7305	Schedule C, line 47
WH056	Home Office Costs/Indirect Care (Salary)	7310	Schedule C, line 48
WH058	Plant Operations/Maintenance Supervisor	7320	Schedule C, line 50
WH059	Plant Operations and Maintenance	7330	Schedule C, line 51
WH060	EAP Administrator - Indirect Care	7525	Schedule C, line 59
WH061	Self-Funded Programs Administrator - Indirect Care	7530	Schedule C, line 60
WH062	Staff Development - Indirect Care	7535	Schedule C, line 61
WH063	EAP Administrator - Other Protected	6057	Schedule B-1, line 22
WH064	Self Funded Programs Admn. - Other Protected	6058	Schedule B-1, line 23
WH065	Staff Development - Other Protected	6059	Schedule B-1, line 24

## 10. Schedule C-3, Cost of Services from Related Parties

**Related Party** – means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed in the ORC and OAC.

## 11. Schedule D-1, Analysis of Property, Plant and Equipment

This schedule should tie to Schedule E, (balance per books) property, plant, and equipment section.

## 12. Schedule D-2, Capital Additions and/or Deletions

Completion of this schedule is optional if the detailed depreciation schedule is submitted which includes all criteria noted on Schedule D-2 except for columns 8 and 11. Columns 12 and 13 are mandatory only in the event of an asset deletion.

## 13. Schedule E, Balance Sheet

Enter balances recorded in the facility's books at the beginning and at the end of the reporting period in the appropriate columns. Where the facility is a distinct part of a NF or ICF-IID, enter total amounts applicable only to the distinct part.

## 14. Schedule E-1, Return on Equity Capital of Proprietary Providers

Schedule E-1 is provided for computing reimbursable equity, the average equity capital amount, and the amount of return which is included in allowable costs.

### Page 1 of 2

Lines 1 through 21 - calculate equity reimbursable under Medicaid regulations.

Note: Lines 8 through 21 - Must specifically identify any amounts entered. An example of amounts that may be included on these lines is intercompany accounts.

### Page 2 of 2

### Lines 23 through 34:

**Column 2:** Enter the equity capital as of the beginning of the reporting period, as computed on Schedule E-1, Page 1 of 2, line 22, column 1. This amount will be the same for all months during the period.

**Column 3:** List, by month, capital investments made during the period. Capital investments include cash and other property contributed by owners and proceeds from the issuance of corporate stock. Do not include loans from owners. The amount entered on the appropriate line in column 3 is carried forward to subsequent months in the period, and is increased by additional contributions in the month(s) in which such contributions are made.

**Column 4:** Enter net gain or loss from the disposition of assets. This column indicates the cumulative amount for the period.

**Column 5:** Enter amounts withdrawn by owners or disbursed for the personal benefit of owners as well as the amounts paid as dividends to corporate stockholders. This column indicates the cumulative amount for the period, e.g., if withdrawals occur at the rate of \$600 per month, the first month of the period will show \$600, the second month \$1200, etc. However, if withdrawals are made and are reflected in the profit or loss for the period, e.g., salaries, the

withdrawals should not be entered in this column.

**Column 6:** Enter other changes in equity capital such as loans from owners (increases) and repayments of same (decreases). Unrestricted donations and contributions are also entered in this column (refer to CMS Publication 15-1). Beginning with the first month in which a transaction occurs, the applicable amount is carried forward to subsequent months, and is increased by additional loans or decreased by repayment of loans.

**Column 7:** Equity capital increases or decreases as income is earned or as losses are incurred by the provider during the reporting period. The net amount of change in equity capital, from this category of transactions, is determined by analyzing the difference between equity capital at the beginning of the period and equity capital at the end of the period. From this net increase or decrease in equity capital are subtracted the amounts included under the other categories of changes on Schedule E -1, columns 3 through 6. The remainder represents the increase or decrease due to operations; however, any amount for a return on equity capital included in the interim payments is further subtracted from this remainder. The increase or decrease due to operations is considered as earned uniformly during each month of the reporting period and affects equity capital cumulatively. For example, if the net increase due to profits in operations for 12 months is \$24,000,

\$2,000 would be shown in the first month, \$4,000 in the second month, etc.

**Column 8:** Add columns 2 through 7. If the result is a negative amount, enter zero. Add the equity capital reported in column 8, etc. and indicate the total on line 35. The total on line 35 shall include only positive monthly balances.

**Line 36 - Return on Equity:**

**Column 3:** The rate of return used is an estimate based on the Commerce Clearing House Table of Interest Rates, and will be revised upon issuance of the appropriate update of the above publication. This is only an estimated rate of return and as such the resulting per diem should be used for budgeting purposes only.

**15. Attachment 1 - Revenue Trial Balance**

Column 2: Enter total revenue for each line item.

Column 3: Enter any adjustments. Detail the adjustment(s) on your exhibit and submit with the cost report.

**16. Attachment 2, Adjustment to Trial Balance**

**Columns 2 and 3, lines 1 through 20:** Enter the appropriate adjustments as necessary to comply with CMS 15-1, federal regulations, state laws, and Ohio Medicaid program regulations. Items included on Attachment 2 must have attached supportive detail. Cost adjustments for related party transactions must offset the appropriate expense account in column 4 of Schedules B-1, B-2, C and D

**Column 5, lines 1 through 20:** In column 5, cross-reference adjustments to the appropriate expense account number. Carry the adjustment in column 4 to the appropriate expense account on Schedules B-1, B-2, C and D, column 4.

Note: All adjustments to expense accounts should be made to the appropriate line of Schedules B-1, B-2, C and D and the appropriate expense account number entered on Attachment 2, column 5.

**Column 6, lines 1-20, line reference from Attachment 1 (if applicable):** After completing Attachment 2 adjustments to expense Schedules B-1, B-2, C and D, column 4 will be automatically populated and the adjusted total expenses (Schedules B-1, B-2, C and D, column 5) will be computed.

**17. Attachment 3, Supplemental Information**

Attach requested documentation as instructed.

**18. Attachment 4, Paid Non-Medicaid Leave Days**

Record the monthly non-medical leave days paid for by payers other than DODD.

**19. Attachment 6, Wage and Hour Survey**

Complete Attachment 6 per instructions to provide necessary information on the wage and hour supplement. There must be corresponding hours listed if wages are indicated.

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 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.)].

**20. Attachment 7, Addendum for Disputed Cost**

This Attachment is for the reporting of costs as specified in section 5124.105 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.