

INSTRUCTIONS FOR JFS 03421 OUTPATIENT CLINIC COST REPORT

The information necessary for the completion of the Outpatient Clinic cost report has been separated into three (3) distinct parts:

- Part I - Introduction
- Part II - Terms and Definitions
- Part III - Instructions For The Completion Of The Outpatient Clinic Cost Report

PART I: INTRODUCTION

This cost report will be used by Outpatient Clinics participating in either the Medicaid-covered Outpatient Health Facility program (OHF) or the Ohio Federally Qualified health Center program (FQHC).

The current Outpatient Health Facility program was implemented from Am. Sub. H.B. 291, which recognized outpatient Health facilities as a separate category of medical care providers under the rules governing the administration of the Medicaid program.

The FQHC program was developed in response the Section 6404 of the Omnibus Budget Reconciliation Act (OBRA) 1989. Effective January 1, 2001 the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) mandated that the states pay FQHCs on a prospective payment system. FQHCs only need to file a cost report for a if they are a new FQHC provider, are adding a new service or requesting a Change in Scope review as described in 5101: 3-28-09 of the Ohio Administrative Code.

To assure each provider's total costs are accurately and properly reported, a more detailed cost report was developed. The new cost report includes many new schedules and workpapers to aid the provider in reporting the clinic's total costs. Reimbursement rates will be developed from the cost report for the following clinical care centers:

- | | |
|-----------------------------------|------------------|
| 1) Medical Services | 8) Vision Care |
| 2) Laboratory (OHF only) | 9) Podiatry |
| 3) Radiology (OHF only) | 10) Chiropractic |
| 4) Dental Services | |
| 5) Speech Therapy Services | |
| 6) Mental Health Services | |
| 7) Transportation | |

OHF's will receive a rate for each type of service. FQHC's will receive a core services rate for Medical (including Lab and Radiology); a core services rate for Clinical Social Worker and Psychology (Mental Health Services); and non-core services rates for each other covered service as described above.

PART II: DEFINITIONS

In addition to the following definitions, governmental providers are required to comply with cost allocation principles found in OMB Circulator A-87 “Cost Principles for State, Local and Indian Tribal Governments” (Federal Register/Vol 70, No 168/Wednesday August 31, 2005. In instances where cost allocation principles in OMB A-87 conflict with the following definitions, governmental providers must always use the OMB A-87 principles.

Accrual Basis of Accounting - - Revenue is recorded in the period earned regardless of when it is received, and expenses are recorded in the period they are incurred regardless of when they are paid (Provider Reimbursement Manual, HCFA 15-1, Section 2302.1). All providers except governmental institutions must complete the cost report using the Accrual Basis of Accounting.

Administrative Time - Time spent not providing Direct Patient Care. Administrative time includes but is not limited to any paid time in which a medical professional is attending classes, seminars, or meetings. A portion of the Medical Directors time spent on evaluations, management reports and physician recruitment must also be included. Do not include paid time off, i.e., vacations or paid sick leave.

Cash Basis of Accounting - Revenues are recognized when received, and expenses are recognized when paid (HCFA 15-1, Section 2302.2). The cash basis of accounting can only be used by governmental institutions.

Chiropractic Encounter - a face-to-face contact between a Chiropractor and a patient for the provision of covered "Chiropractic Services".

Contracted Personnel Compensation (services under arrangement) - Compensation paid to personnel under contract with the clinics to provide services. The contract usually shows either a hourly amount or a total dollar amount that is paid by the clinic under the contract. The person receiving the compensation is usually responsible for their own taxes and is not an employee of the clinic. A form 1099 is issued to reflect total yearly compensation paid by the clinic to the contracted personnel.

Dental Encounter - A face-to-face contact between a Dentist or Dental Hygienist, or Oral Therapist under the supervision of a Dentist and a patient for provision of "covered dental services".

Depreciable Assets - According to the Provider Reimbursement Manual, HCFA 15-1, Section 108.1, a depreciable asset is defined as having an estimated useful life of at least two (2) years and a historical cost of at least \$500.

Direct Care Time - The time a medical professional spends in face-to-face encounter with a clinic patient. This also includes any time spent updating medical records. This category of time will be used in the Test of Reasonableness Rate calculations.

Donated Services - To qualify as a allowable, reimbursable cost according the Provider Reimbursement

manual, HCFA 15-1, Section 700, all of the following conditions must be met: 1) The non-paid worker must work more than twenty (20) hours per week in various types of full-time positions that are normally occupied by paid personnel. 2) The value of the services performed must be recorded as an operating expense and must be identifiable in the records of the clinic as a legal obligation and 3) The services are rendered without direct remuneration (salaries, wages, or gifts) to the non-paid workers by either organization.

Home Office Costs - Costs incurred by the Home Office first must be allowable according the Medicare/Medicaid Regulations (HCFA-Pub. 15-1, Provider Reimbursement Manual). Once the non-allowable costs have been removed the process of allocating the Home Office Costs should begin. There are three (3) steps for the accurate allocation of costs:

Directly allocable costs - Costs incurred for the benefit of, or costs which are directly attributable to a specific provider or non-provider activity must be allocated directly to where they are incurred. Costs of this type would include mortgage interest paid by the Home Office for a particular entity. These costs should be reported in the appropriate cost center of the applicable clinic.

Costs allocable on a functional basis - Such costs should be assigned to the appropriate clinic=s applicable cost report cost center based upon an independent statistic. Such costs might include, but are not limited to, central purchasing costs allocated by number of requisitions, or central payroll costs distributed by payroll checks issued.

The remaining costs are considered pooled costs. HCFA recommends these costs be allocated by number of encounters. For providers with both core, non-core, and non-reimbursable direct care areas the total number of encounters should be used. Allocated pooled costs should be reported on Schedule B-1 as a "Other" Administrative cost.

The methodology and the statistics used must be documented and submitted when filing the Outpatient Clinic Cost Report, along with any work papers developed to assign and allocate Home Office Cost. Any desired changes in the methodology and/or statistics used in subsequent cost report periods must be submitted in writing for Department review and approval. For further detail concerning Home Office Cost allocation, please consult Section 2150 - 2153 in Chapter 2100 of HCFA-Pub. 15-1, Provider Reimbursement Manual.

Hours of Operation - The total amount of hours the clinic is open to provide direct care services to patients.

Laboratory Unit-of-Service (**OHF Program Only**) - Under the OHF program, laboratory services will be reported, billed and paid on a unit of service basis. Each individual laboratory procedures or battery of procedures represents one unit-of-service.

Medical Encounter - A face-to-face encounter between a medical professional and a clinic patient for the provision of covered "medical service".

Under the FQHC program the medical professional can be any one of the following: Physician, Physician's Assistant, Nurse Practitioner, Nurse Midwife or Registered Nurse.

Under the OHF program the medical professional can be any one of the following: Physician, Physicians Assistant, Nurse Practitioner, Nurse Midwife, Registered Nurse or Licensed Practical Nurse.

Mental Health Encounter - a face-to-face encounter between a licensed Psychologist or clinical Social Worker for the provision of covered "clinical social work or psychology services".

Non-Reimbursable Costs - Expenses for items and services paid for by another governmental entity, e.g., WIC and Sickle Cell, or costs of services not covered under the FQHC or Outpatient Health Facility program, e.g., Pharmacy.

Podiatry Encounter - A face-to-face encounter between a podiatrist, or a physician assistant or nurse practitioner working under the direction of a Podiatrists, for covered "podiatric services".

Physical Therapy Encounter - A face-to-face encounter between a Physician, Physical Therapist, or a Mechanotherapist and a patient for receipt of a covered "physical therapy service".

Radiology Unit-of-Service (**OHF Program Only**) - Under the OHF program, an individual radiology procedure covered under Medicaid, reported, billed and paid on a unit-of-service basis.

Speech and Hearing Encounter - A face-to-face encounter between an Audiologist or Speech Pathologist and a patient for the provision of "covered speech and hearing services".

Time Studies - Periodic time studies, in lieu of ongoing time reports, may be used to allocate direct salary and wage costs. However, the time studies used must meet the following criteria as per the Provider Reimbursement Manual, HCFA 15-1, Section 2313.2 (E).

- 1) The time records to be maintained must be specified in a written plan, subject to review by ODHS.
- 2) A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.
- 3) Each week selected must be a full work week (Monday to Friday, Monday to Saturday or Sunday to Saturday).
- 4) The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a twelve (12) month period, three (3) of the twelve (12) weeks in the study must be the first week beginning in the month, three (3) weeks the 2nd week beginning in the month, three (3) weeks the 3rd and three (3) weeks the fourth.
- 5) No two (2) consecutive months may use the same week for the study, e.g., if the second week

beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

- 6) The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocated the costs of prior or subsequent cost reporting years.

The time study must be provider specific. Thus, chain organizations may not use a time study from one site to allocate the costs of another site or a time study of a sample group of sites to allocate the costs of all sites within the chain

Transportation Unit-of-Service - An instance of one-way transportation of a patient to or from the clinic. Transportation must be provided on the same date as another billable encounter and shall be limited to one unit of transportation for each instance of one-way transportation of family members, patients or other patient residing at the same address. If the family member is serving as a medically necessary escort (minor child or disabled individual), costs are allowed to cover the cost of their ride, except if the vehicle is being shared and the pick-up point and the drop-off point are the same. In that scenario, there should be a single unit of cost for the one-way transport. Including the family member when the mother does not have child care for a sibling is not a coverable cost. However, it is permissible to allow this if the vehicle can accommodate the family member without cost. Transportation of "other patients residing at the same address" is one unit. If the vehicle is taking more than one individual who resides at the same address and dropping of at the same clinic there should be only one unit charged. The cost would be the same regardless of how many people are in the vehicle.

Wages - Compensation to clinic employees for services provided, in which applicable federal, state and local taxes and deducted from gross wages. The clinic employee receives a W-2 statement a year end.

Part III - Instructions For The Completion Of The Outpatient Clinic Cost Report

The various schedules and workpapers for the Outpatient Clinic cost report are an integral part of the calculation of reimbursable costs and must be completed by all clinics. When correctly completed, the clinic=s total costs should be reflected on the cost report.

To assist with completion of the Outpatient Clinic Cost Report, an outline of the main sections with accompanying subsections are shown below:

Schedule A	(Home Office Cost)
Schedule A-1	(Summary of Encounters)
Schedule A-2	(Square Footage & Medical Record Hour Statistics)
Schedule A-3	(Offsite Surgical Procedures)
Schedule B	(Depreciation)
Schedule C	(Other Non-reimbursable Program Costs)
Schedule C-1 thru C-7	(Expense Trail Balance)
Schedule D-1 thru D-4	(Employee Professional Services)
Schedule DA-1 thru DA-4	(Contract Personnel)

Schedule E	(Place Holder For Future Expansion)
Schedule F	(Related Organizations)
Schedule G	(Revenue Trial Balance)
Certification Page	(Statement of Certification)

The facility name, Medicaid provider number, and cost reporting period must appear as indicated on the top of each page. This information will specifically identify each page and prevent lost pages should the cost report become separated.

To assure that all areas of the cost report have been completed, follow instructions for each section. Improperly filed cost reports may result in a delay in the issuance of new rates, rates which are higher/lower than they should be resulting in over/under payments, and/or penalties. The cost of non-reimbursable programs must be included where indicated.

Schedule A - Home Office Cost

This schedule must be completed by all sites which are part of a network and have services and/or administrative oversight provided by a corporate office. Additionally, governmental providers must submit documentation that demonstrates the allocation of any local health department costs to the individual FQHC cost reports, and ensures the basis for such allocation is functionally related to the costs.

Home Office Cost Centers: Rows 1 - 19

Enter the Salaries, Contract or Supplies cost as appropriate for each line item.

Column 1: Salaries

Enter the salaries cost related to the home office for each line item.

Column 2: Contracts

Enter the contracts cost related to the home office for each line item.

Column 3: Supplies and Other Costs

Enter the supply costs related to the home office for each line item.

Column 4: Total

Sum the Salary, Contract and Supply cost for each line item.

Columns 5, 6 & 7: Reclassification of Expenses

Enter re-class amounts as positive or negative numbers as appropriate for each line item. Use the re-class columns to move expenses between cost centers. Example; If the Medical Director's salary is buried in the Physician Wages the cost associated with the Medical Director would need to be re-classed to the Administrative Costs. Note: The total of all re-classes must be zero (0).

Columns 8, 9 & 10: Adjustments to Expenses

Enter adjustments as positive or negative numbers as appropriate for each line item. Use the Adjustment columns to remove costs not associated with the site. Example: A dentist is paid entirely out of Site A but keeps hours at both Sites A and B. The Cost of the Dentist's time at Site B would be a negative adjustment to Dentist Wages on Site A and a positive adjustment on Site B.

Column 11: Total

Sum Columns 4 through 10 for each line item.

Row 20: Total Home Office Costs

Sum Rows 1 - 19 for each column.

Allocation of Home Office Costs

Row 21: Clinic Name

Enter the name of each clinic/site in the network. NOTE: The clinic/site for which the cost report is being prepared MUST be entered in Column 1.

Row 22: Total Clinic Costs (Schedule C-7).

Enter the total clinic costs, excluding home office costs for each clinic/site in the network.

Row 22, Column 11: Total Network Costs

Sum the Total Clinic Costs Columns 1 - 10.

Row 23: Percentage of Total Costs

Calculate the percentage of Clinic Costs to Total Network Costs (Clinic Costs / Network Costs) rounded to six (6) decimal places.

Row 24: Home Office Allocation

Calculate the clinic/site specific home office costs by multiplying the Total Home Office Costs (Row 20, Column 11) by the clinic share of Total Costs (Row 23). The amount shown in Row 24, Column 1 will be entered into Schedule C-2, Row 12, Column 3.

Schedule A-1: Summary of Encounters

For each type of service in the column labeled Medicaid enter the encounters, by month, for which the clinic has been paid or expects to be paid by ODJFS.

For each type of service in the column labeled Total enter the encounters, by month which were provided to patients. Include all encounters, as defined in the definitions, regardless of the payor (private pay, uninsured, Medicaid, Medicare, insured, etc.).

[Providers must maintain documentation to support the number of encounters reported.](#)

Medical and OB/GYN Encounters; If the site provides OB Services report OB encounters, both Medicaid and Total separately from Medical encounters. Be careful not to duplicate OB and Medical

encounters.

Schedule A-2: Square Footage and Medical Record Statistics

Governmental providers are required to comply with cost allocation principles found in OMB Circulator A-87. In instances where cost allocation principles in OMB A-87 conflict with HCFA 15-1, governmental providers must always use the OMB A-87 principles.

Column 1: Square Footage

For each cost center enter the amount of square footage utilized by the cost center. Examples of items to include are;

- Facility Costs: Mechanical Rooms, Custodial/Janitorial Rooms and General Facility Spaces
- Administrative: Business Office, Medical, Nursing and/or Executive Director
- Medical Records: Medical Records Office, Medical Records Storage Areas
- Medical: Exam Rooms, Physician Offices
- Common / Public Areas: Areas such as Restrooms, Hallways, Waiting Rooms and Lobbies could be allocated to other cost centers based on total square footage.
- Exam Rooms used for multiple services should be allocated based on the amount of time used or number of encounters performed in that room. Example: A 10 x 10 (100 sq ft) exam room is used 60% for Medical and 40% for Podiatry. In this case 60 sq ft would go to Medical and 40 sq ft would go to Podiatry.

Column 2: Medical Record Hours

For each cost center enter the number of hours spent maintaining the medical records for that service. It is acceptable to use Total Facility Encounters (including non-reimbursable) instead of hours.

NOTE: For each type of service that you provide, there should be an allocation of both square footage and medical records.

Schedule A-3 Offsite Surgical Procedures

In the column labeled >Medicaid= enter the number of Medicaid encounters, by month, for which the clinic has been paid or expects to be paid for AOffsite Surgical Procedures@ by ODJFS.

In the column labeled >Total= enter the total number of facility encounters, by month, for which the clinic has been paid or expects to be paid for “Offsite Surgical Procedures” for all service providers.

In the column labeled >Reimbursement= enter the amount, by month, of ODJFS Medicaid payments for “Offsite Surgical Procedures”.

Schedule B: Depreciation

It is the responsibility of the provider to maintain appropriate asset ledgers which will facilitate the

calculation of the total depreciation for each category of service. Providers are required to use the straight line method for calculating depreciation. Straight line depreciations is calculated by dividing the cost of the asset by the asset's useful life. The Provider Reimbursement Manual, HCFA PUB 15-1, Section 104.17, requires that providers use the "Estimated Useful Lives of Depreciable Hospital Assets" as published by the American Hospital Association. Governmental providers are required to comply with cost allocation principles found in OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments" (Federal Register/Vol 70, No 168/Wednesday August 31, 2005. In instances where cost allocation principles in OMB A-87 conflict with HCFA 15-1, governmental providers must always use the OMB A-87 principles.

This schedule is divided into two sections; Fixed Assets and Moveable Equipment. Enter the following information for each type of service.

Column 1: Cost at Beginning of Period – Enter the total cost of all assets in the service category. This should be equal to the amount that is in Column 4 from the previous year.

Column 2: Additions – Enter the total cost of newly acquired assets for each category of service.

Column 3: Disposals – Enter the total cost of assets which were disposed of during the year. Enter this amount as a positive number.

Column 4: Cost at End of Period – Enter the sum of Columns 1 and 2 minus Column 3.

Column 5: Depreciation Beginning of Period – Enter the amount of accumulated depreciation for each category of service.

Column 6: Depreciation This Period – Enter the depreciation expense for the current period.

Column 7: Depreciation on Disposals – Enter the amount of depreciation remaining on assets that were disposed. This should be reduced by the salvage or sale value of the asset at the time of disposal.

Column 8: Depreciation End of Period – Sum of Columns 6 and 7.

Column 9: Book Value at End of Period – Column 5 minus Column 8.

Schedule C: Other Non-Reimbursable Program Costs

Schedule C is divided into three (3) cost reporting areas. The areas are (1) non-reimbursable Encounters, (2) non-reimbursable salaries cost and (3) non-reimbursable Contract Services Cost. Totals for each service should be entered on the appropriate line of Schedule C-7, Part XVI. Supply costs for non-reimbursable programs should be entered directly on Schedule C-7. For FQHCs, please note that any Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) radiology services for which FQHCs receive CDC funding must be classified as "OTHER NON-REIMBURSEABLE PROGRAM COSTS" in Schedule C, under Cost Center 4 "Radiology."

Column 1: Non-Reimbursable Encounters. Enter the encounters area of service for all non-reimbursable programs, i.e., Pharmacy, WIC, Sickle Cell, etc.

Column 2 through 5: Salary costs only. Enter the salaries by line item and in the column corresponding to the appropriate program.

Column 6: Salary Totals. Each line should be then totaled across and each column should be totaled down. The amount on the 'Total Line' line in Column six (6) should reflect the total across of the 'Total' line as well as the total down of Column six (6).

Columns 7 through 10: Contract Services costs only. Enter the contract services cost by line item and in the column corresponding to the appropriate program.

Column 11: Contract Services Costs Totals. Each line should be then totaled across and each column should be totaled down. The amount on the 'Total Line' line in Column eleven (11) should reflect the total across of the 'Total' line as well as the total down of Column eleven (11).

Schedules C-1 through C-7: Expense Trial Balance

Column 1: Salaries

Enter the salaries cost related to each line item.

Column 2: Contracts

Enter the contracts cost related to each line item.

Column 3: Supplies and Other Costs

Enter the supply costs related to each line item.

Column 4: Total

Sum the Salary, Contract and Supply cost for each line item.

Columns 5, 6 & 7: Reclassification of Expenses

Enter re-class amounts as positive or negative numbers as appropriate for each line item. Use the re-class columns to move expenses between cost centers. Example; If the Medical Director=s salary is buried in the Physician Wages the cost associated with the Medical Director would need to be re-classed to the Administrative Costs. Note: The total of all re-classes must be zero (0).

Columns 8, 9 & 10: Adjustments to Expenses

Enter adjustments as positive or negative numbers as appropriate for each line item. Use the Adjustment columns to remove costs not associated with the site. Example: A dentist is paid entirely out of Site A but keeps hours at both Sites A and B. The Cost of the Dentist's time at Site B would be a negative adjustment to Dentist Wages on Site A and a positive adjustment on Site B.

Column 11: Total

Sum Columns 4 through 10 for each line item.

Schedule C-1:

Part I. Fringe Benefits and Taxes. Enter the cost of Fringe Benefits and Taxes, i.e., Health Insurance, FICA, FUTA, OBES, etc. Do not re-class expenses from this Part into other Parts of the cost report.
Fringe benefits and taxes must be reported as incurred and not allocated as a percentage of salaries.

Part II. Facilities Cost: General facility expenses, rent, building insurance, utilities, property taxes, housekeeping, etc.

Schedule C-2:

Part III. Administrative Costs: All costs associated with the general functioning of the facility. Executive Director, Medical Director, Nursing Director, Secretarial/Support Staff, Postage, Telephones, Travel, Data/Computer Systems, etc.

Part IV. Medical Records Costs: All cost associated with maintaining the medical records of the patients. This would include, but not be limited to, clerical staff, filing cabinets/equipment, supplies purchased directly for use on patient records (file folders, labels, alpha/number labels, etc.).

Schedule C-3:

Part V. Medical Service Costs

Section A: Enter cost associated with Medical Wages. Physician, Nurses. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Section B: Enter the cost of supplies and equipment directly associated with providing direct care to the patient.

Part V-B. OB/GYN Service Costs: Enter cost associated with OB/GYN Wages (*i.e.* Physician, Nurses), and the cost of supplies and equipment directly associated with providing direct care to the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Schedule C-4:

Part VI. Laboratory Costs: Enter cost associated with Laboratory Wages, (*i.e.* Phlebotomist, Lab Technicians), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part VII. Radiology Costs: Enter cost associated with Radiology Wages, (*i.e.* Radiologists, Radiology Technicians), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part VIII. Dental Service Costs: Enter cost associated with Dental Wages, (*i.e.* Dentist, Dental Assistants/Technicians), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Schedule C-5:

Part IX. Speech & Hearing Therapy Costs: Enter cost associated with Speech and Hearing Therapy Wages, (*i.e.* Speech Pathologist/ Audiologist), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part X. Mental Health Service Costs: Enter cost associated with Mental Health Services Wages, (*i.e.* Psychologist, Clinical Social Workers), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part XI. Physical Therapy Costs: Enter cost associated with Physical Therapy Wages, (*i.e.* Physical Therapist), and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Schedule C-6:

Part XII Transportation Costs:

Enter cost associated with Drivers= Wages and the cost of supplies, repairs and equipment directly associated with providing Transportation services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part XIII Vision Care Costs:

Enter cost associated with Optometrist/Ophthalmologist Wages and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part XIV Podiatry Service Costs:

Enter cost associated with Podiatrist Wages and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Schedule C-7:

Part XV. Chiropractic Costs: Enter cost associated with Chiropractors Wages, and the cost of supplies and equipment directly associated with providing those services related to the care of the patient. Do not include the costs of fringe benefits and taxes, these should be reported in Part I on Schedule C-1.

Part XVI. Non-Reimbursable Centers: The totaled Non-reimbursable Salaries and Contracts cost totals

from Schedule C are cared forwarded to Columns 1 and 2 respectively. In Column 3 enter for all non-reimbursable programs, i.e., Pharmacy, WIC, Sickle Cell, etc. non-reimbursable supplies and other non-reimbursable costs.

Schedules D-1 through D-4: Direct Care Employee Professional Services

Schedules D-1 through D-4 is for Direct Care Clinic employees, i.e. Physicians, Dentist, An employee is one who has applicable federal, state, and local taxes deducted from gross wages and receives a W-2 at the end of the year reporting total wages and deductions. On the appropriate Schedule for each type of service provided by the clinic, list the professionals by name and title (MD, RN, PA). Allocate each person's wages and work time by either time cards, time studies or some other allocation method.

Column 1: Administrative Duties Hours

Enter the calculated number of hours spent performing administrative related professional services for each type of service provided by the clinic.

Column 2: Administrative Duties Wages

Enter the wages received for administrative related services provided for each type of service provided by the clinic.

Column 3: Direct Care Hours

Enter the hours spent providing care for professional services for each type of service provided by the clinic.

Column 4: Direct Care Hours - Other

Enter the hours spent providing care by nurses (other than Nurse Practitioners), Radiologist, Radiologist Technician, Pathologist, and other laboratory.

Column 5: Direct Care Wages

Enter the wages for direct professional care for each type of service provided by the clinic.

Column 6: Paid Leave Hours

Enter the paid leave hours for professional care (*i.e. vacation, sick leave etc.*) for each type of service provided by the clinic.

Column 7: Paid Leave Wages

Enter the paid leave wages for professional care (*i.e. vacation, sick leave etc.*)for each type of service provided by the clinic.

Column 8: Total Hours

Each line should be then totaled across and each column should be totaled down. The amount on the 'Total Line' line in Column eight (8) should reflect the total across of the 'Total' line as well as the total down of Column eight (8).

Column 9: Total Wages

Each line should be then totaled across and each column should be totaled down. The amount on the 'Total Line' line in Column nine (9) should reflect the total across of the 'Total' line as well as the total down of Column nine (9).

Should there be more personnel than there are lines for a service, prepare a work sheet with the same columns as Schedules D-1 to summarize the information required. Carry the totals from your supplemental work sheet to the cost report.

Schedules DA-1 through DA-4: Direct Care Contracted Professional Services

Direct Care Services can also be rendered by contracted personnel. A contracted person is one who has a contract to receive compensation, usually without payroll taxes being withheld, is paid only for hours worked and receives a federal form 1099 at year reflecting their total compensation. **Complete Schedules DA-1 through DA-4 in the same manner as you completed the Schedule D series.**

Schedule E: The cost report does not include a Schedule E. It is a place holder to be used in the event future expansion and revision of the cost report is necessary.

Schedule F: Cost Of Services From Related Organization

Schedule F must be completed by the provider. The Provider Reimbursement Manual, HCFA 15-1, Chapter 10 defines "related" in Section 1002 as follows:

1002.1 "The provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies."

Based upon this definition, related party status is determined depending upon the factors of ownership and control. To understand the principles of ownership and control requires further definition clarification in the Provider Reimbursement Manual, HCFA 15-1, Chapter 10.

1002.2 "Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization or organization serving the provider."

1002.3 "Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution."

Applying these two (2) criteria will assist in determining related party status. If the answer to Part A of Schedule F is "yes", the provider is required to answer Parts B and C. Costs of items reported in Part B will be used to determine if such costs exceed the price of comparable services or supplies that could be purchased elsewhere. Part C notifies the department of owners' names by individual and by company name, as well as ownership percentages.

Page two (2), Part D, of Schedule F is a brief questionnaire collecting information regarding offsite surgical information, non-reimbursable cost, and depreciation.

Note: If further information regarding related party other than the definition provided above is desired, please consult the remainder of Chapter 10 in HCFA-Pub. 15-1. Governmental providers are required to comply with cost allocation principles found in OMB Circulator A-87. In instances where cost allocation principles in OMB A-87 conflict with HCFA 15-1, governmental providers must always use the OMB A-87 principles.

If, however, the answer to Part A is “No” Schedule F is considered complete.

Schedule G: Revenue Trial Balance

The Revenue Trial Balance is designed to summarize all revenues earned for this cost report period. The information will be used to ascertain the clinic=s financial standing, for comparison purposes, year to year , and to assure proper revenue offsets have taken place in the reporting of allowable costs. **As with expenditures, revenues must be reported on an accrual basis except for governmental institutions.**

Direct Care Revenue Section (lines 1 - 16)

Enter according to program source and type of service the accrued revenue for direct care.

Other Programs Revenue Section (lines 17 - 27)

Enter according to program (*i.e. WIC, Sickle Cell, and Grants, etc.*) other sources of revenue.

Other Income (lines 28 - 36)

Enter according to revenue source other income.

Line 37 - enter the totals for all revenues.

Schedule H: Statistics And Other Data

Type of Control Section

Enter in this area by checking one from the list of categories (either under the voluntary nonprofit or government non-federal) the type of control that is applicable to your facility.

Statistical Data Section

Enter in column one (1) by type of service the hours of operation for the cost report period.

The encounter data in Columns two (2) and three (3) are forwarded from Schedule A- 1. Column four (4), the Medicaid utilization is calculated by dividing the covered Medicaid encounters (column 2) by total facility encounters (column 3).

Schedule I, Pages 1 & 2: Summary Of Expenses After Reclassification & Adjustments

The data on the Schedule I is a summary of expenses after reclassification and adjustments. No data entry is necessary since the data is forwarded from the appropriate schedules in the cost report.

Schedule J: Summary Of Professional Services

The data on the Schedule J is a summary of professional services hours and wages. No data entry is necessary since the data is forwarded from the appropriate schedules in the cost report.

Certification Statement

The facility Administrator, Director, or officer in authority must sign the certification page of the cost report. As a requirement of current Medicaid regulations (42 CFR 455.18, 455.19) only a signed report can be submitted to the ODJFS, Bureau of Health Plan Policy, Financial Management Unit.

A cost report will be considered complete and accepted for processing, whether originals or copies, when an original signature appears on the certification page.

Cost Report Submission

The following items should be submitted with each cost report:

- Trial Balance – A trial balance prepared from the site's financial records and for the same period covered by the cost report.
- A disc containing the electronic version of the cost report schedules.
- Two printed copies of the cost report.
- Any other documentation supporting the requested change in scope as required by 5101: 3-28-09 of the Ohio Administrative Code.

The cost report and supporting documentation should be submitted to ODJFS, Bureau of Health Plan Policy, Financial Management Unit.