MEDI-CAL SUPPLEMENTAL COST REPORT

SCHEDULES

Hospital Name

Fiscal Year End

INDEX OF SCHEDULES

Schedule 1
MEDI-CAL COST REPORT ACCEPTANCE

The following are the most common reasons for the Medi-Cal cost reports being returned to providers for insufficient or incorrect information. Attention to these details will result in faster processing and acceptance of your report and avoidance of possible withhold against payments:

1. Financial Statements not submitted	Worksheet G Series is not an acceptable substitute for financial statements.
2. Working trial balance not submitted	Submit a copy of the working trial balance
3. Medi-Cal supplemental schedules (DHS 3092) and RDB schedules (DHS 3094) incomplete	Complete and submit required Medi-Cal supplemental schedules (DHS 3092) and RDB schedules (DHS 3094).
4. Appeal items included in body of cost report	All appeal items must be removed from the body of the cost report. The estimated Medi-Cal impact of appeal issues may be added on Worksheet E-3, Part III, line 59, (CMS 2552-96).
5. Certification page of cost report not signed	Proper signature must be on Cost Report Certification, Schedule 3, and on Worksheet S, Part I (CMS 2552-96).
6. Facility's type of control not disclosed	Complete Worksheet S-2 in full (CMS 2552-96).

Schedule 2
MEDI-CAL REQUIRED WORKSHEETS AND SCHEDULES CHECK LIST

This Cost Report Worksheet and Schedules Check List is provided to identify each work sheet and schedule that must be completed and included as part of the Medi-Cal cost report. If the same worksheet or schedule is needed more that once, please use a separate blank form to report the data. Cost reports submitted without these worksheets and schedules will be returned as incomplete. Other supplemental worksheets and schedules not listed may be submitted, depending upon the individual circumstances of the hospital.

Worksheet/Schedule	Part	Completed	N/A
Core Worksheets—(CMS 2552–96)			
S	I and II		
S–1	I		
S–2			
S–3			
A			
A–6			
A–8			
B	I		
B–1	II		
C			
D–1	I–III		
D–4			
G to G–3			
Medicare Worksheets (CMS 2552–96)			
A–8–1			
E–3			
A–8–2	III		
Financial statements			
Working trial balance			
Medi-Cal Supplemental Cost Report Schedules (DHS 3092)			
Schedule 1 Medi-Cal (M/C) Cost Report Acceptance			
Schedule 2 Medi-Cal Required Worksheets and Schedules Check List			
Schedule 3 Certification			
Schedule 4 Provider Questionnaire			
Schedule 5 Provider Based Physicians Questionnaire			
Schedule 6 Summary of Medi-Cal Charges			
Schedule 7 Summary of Medi-Cal Settlement			
Schedule 8 Summary of Medi-Cal Psychiatric Inpatient Hospital Services			
Schedule 9 Summary of Medi-Cal Charges and Ancillary Costs for Rural Health Clinic/Federally Qualified Health Center			
Schedule 10 Summary of Medi-Cal Rural Health Clinic/Federally Qualified Health Center Settlement			
Schedule 11 Medi-Cal Credit Balance Report			

Schedule 3
CERTIFICATION

In accordance with Section 14107.4 of the Welfare and Institutions Code of Regulations:

(a) Any person who, with the intent to defraud, certifies as true and correct any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170, knowingly fails to disclose in writing on the cost report any significant beneficial interest, as defined in subdivision (d), which the owners of the provider, or members of the provider governing board, or employees of the provider, or independent contractor of the provider, have in the contractors or vendors to the providers, is guilty of a public offense.

(b) Any person who, with the intent to defraud, knowingly causes any material false information to be included in any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170 shall be guilty of an offense punishable by imprisonment in the state prison, or by a fine not exceeding five thousand dollars ($5,000), or by both.

(c) The provider's chief executive officer shall certify that any cost report submitted by a hospital to a state agency for reimbursement pursuant to Section 14170 shall be true and correct. In the case of a hospital that is operated as a unit of a coordinated group on health facilities and under common management, either the hospital's chief executive officer or administrator, or the chief financial officer of the operating region of which the hospital is a part, shall certify to the accuracy of the report.

(d) As used in this section, "significant beneficial interest" means any financial interest that is equal to or greater than 25 thousand dollars ($25,000) of ownership interest or 5 percent of the ownership or any other contractual or compensatory arrangement with vendors or contractors or immediate family members of vendors or contractors. "Immediate family" means spouse, son, daughter, father, mother, father-in-law, mother-in-law, daughter-in-law, or son-in-law. Interest held by these persons specified in subdivision (a) and members of these persons' immediate family shall be combined and included as a single interest.

(e) Any person who violates the provisions of subdivision (a) shall be subject to imprisonment in the county jail for a period not to exceed one year or in state prison, or by a fine not to exceed five thousand dollars ($5,000), or both.

(f) Effective with cost report periods ending on or after June 30, 1982, the Department has implemented the provisions of Section 14171.5 of the Welfare and Institutions Code. Pursuant to this section, hospitals that include costs within their Medi-Cal cost reports previously determined by departmental audit to be nonreimbursable, will be subject to a penalty assessment of interest on the improperly claimed amount, and recovery of the cost of state audit. The penalty will be ten percent of the improperly claimed amount, except when it is established that the hospital fraudulently claimed and received payments, in which case the penalty will be 25 percent. Interest will be assessed at the rate specified in subdivision (e), Section 14171, Welfare and Institutions Code.

Hospitals that wish to preserve appeal rights or to challenge the Department's positions regarding appeal issues may claim such costs provided they are identified and presented separately in the cost report. This has been interpreted to mean that the approximate settlement effect of each disputed issue must be calculated on a separate work sheet. Only the total settlement effect of all issues is to be carried forward to cost report Worksheet E-3, Part III, and entered on line 59.

(g) Be advised that continued submission of claims or cost reports for items or services which were not provided as claimed or were not reimbursable under the Medi-Cal program, or were claimed in violation of an agreement with the State, may subject you (your organization) to civil money penalty assessment in accordance with Welfare and Institutions Code, Section 14123.2.

I hereby certify that the attached cost report for the fiscal period_____, was prepared in accordance with the above Welfare and Institutions Code references and, to the best of my knowledge, is a true, correct, and complete statement prepared from the books and records of_____, in accordance with the applicable instructions.

Signature	Title	Date
☐		

Schedule 4
PROVIDER QUESTIONNAIRE

Provider name

Facility address (number, street)	City	State	ZIP code
Mailing address (if different from above)	City	State	ZIP code
Home office/management affiliation address (number, street)	City	State	ZIP code
Contact person	Title		Telephone ( )

Is this cost report being filed on a consolidated basis? ☐ Yes ☐ No

Was the facility a contract hospital during a portion or all of the reporting period? ☐ Yes ☐ No

Contact effective date	Contract number	Contract reimbursement rate

Complete the following Medi-Cal/state program provider numbers for each service component as applicable:

Component Name	Provider Number	Date Certified
Acute inpatient noncontract		
Acute inpatient contract		
Acute inpatient mental health		
Inpatient skilled nursing LTC		
Federally qualified health center—outpatient		
Rural Health Clinic—outpatient		
County medical services program—inpatient		
Other		

Schedule 5
PROVIDER BASED PHYSICIANS QUESTIONNAIRE

The following questionnaire relates to provider-based physicians (PBPs) who perform professional services under contractual arrangements at the facility.

1. For PBPs who perform professional services, does the facility combine bill their services on the Medi-Cal claim form (UB92 form) when billing for services?

   ☐ YES—answer questions 2 and 6

   ☐ NO—answer questions 3, 4, 5, and 6 below if applicable

2. For those PBPs whose services are billed on a combined basis, list the type of professional services performed and the compensation received.

Type of Professional Service	Compensation
	$
	$
	$
	$
	$

If PBP services are subject to cost settlement, please call the Cost Report Acceptance Unit at (916) 650-6696 to secure a schedule to report PBP cost.

3. For those PBPs whose services are billed separately, or directly by the physician, list the services that they provide and the provider number their services are billed under.

Type of Professional Service	Provider Number

4. For those PBPs whose services are billed separately, does the hospital or a related organization perform services relating to billing or collection of payments of those PBPs? ☐ Yes ☐ No

5. If yes to question 4 above, does the facility retain or receive any portion of these fees as compensation for the services the hospital performs? ☐ Yes ☐ No

6. If yes to questions 1 or 5 above, list the PBP services to which this relates, and the amount of compensation received or retained by the hospital for these administrative services.

Type of Professional Service	Compensation
	$
	$
	$
	$
	$

Schedule 6
SUMMARY OF MEDI-CAL CHARGES

Provider name	Provider number

Contract provider number	Fiscal period ending	Effective date of contract

Medi-Cal Charges From Worksheet D-4 (CMS 2552-96, Column 2)	Cost Settlement Title XIX*	Contract Services Title V	Total
Ancillary Service Cost Centers			
Operating room	$	$	$
Recovery room			
Delivery and labor rooms			
Anesthesiology			
Radiology—diagnostic			
Radiology—therapeutic			
Radioisotope			
Laboratory			
Whole blood			
Blood storing, processing, and intravenous therapy			
Intravenous therapy			
Oxygen (inhalation) therapy			
Physical therapy			
Occupational therapy			
Speech therapy			
Electrocardiology			
Electroencephalography			
Medical supplies charged to patients			
Drugs charged to patients			
Renal dialysis			
Emergency			
Total Medi-Cal Ancillary Charges**	$	$	$

Schedule 6
SUMMARY OF MEDI-CAL CHARGES

Inpatient Routine Service Cost Centers			
Adults and pediatrics (general services)	$	$	$
Intensive care unit			
Coronary care unit			
Nursery			
Total Medi-Cal Routine Charges **	$	$	$

* Use this column for noncontract service

** Do these charges agree with cost report Worksheet E-3, Part III, lines 10 and 11? ☐ Yes ☐ No
(If no, please attach an explanation.)

Schedule 7
SUMMARY OF MEDI-CAL SETTLEMENT

Provider name	Provider number

Fiscal period	Contract period
From: Through:	From: Through:

Medi-Cal Cost (CMS 2552-96, Worksheet E-3, Part III)				
Line		**Settlement Noncontract**	**Contract**	**Total***
1	Inpatient operating services	$	$	$
4	Administrative Day Costs			
22	Excess of reasonable costs over customary charges			
59	Appeal issues Total program liability			
22	Deductibles	( )	( )	( )
36	Coinsurance	( )	( )	( )
57	Interim payments	( )	( )	( )
58	Reported settlement due Provider/(State)*	$ ( )	$ ( )	$ ( )

Medi-Cal Days (CMS 2552-96, Worksheet D-1, Parts I and II)				
		Settlement	**Contract**	**Total**
9	Adults and Pediatrics			
43	ICU			
44	CCU			
42	Nursery			

Discharges (CMS 2552-96, Worksheet S-3)				
Acute		**Settlement**	**Contract**	**Total**
	Total discharges			
	Total Medi-Cal discharges			

Administrative Days—Routine		
	Medi-Cal administrative days	
	Per diem rate(s)	$
	Reimbursable amount for routine administrative days	$ **
Administrative Days—Ancillary		
	Medi-Cal ancillary costs	$

Appeal Issues	**Protested Amount *** **	**Medi-Cal Settlement**	**Contract**
1.	$	$	$
2.			
Total	$	$	$

* Settlement figure must agree with the provider's cost report for the cost settlement period.

** To CMS 2552-96, Worksheet E-3, Part III, line 4

*** To CMS 2552-96 Worksheet E-3, Part III, line 59

Schedule 8
SUMMARY OF MEDI-CAL PSYCHIATRIC INPATIENT HOSPITAL SERVICES

Provider name	Provider number	Fiscal period From: Through:

Check one: ☐ Freestanding psychiatric hospital ☐ Acute care hospital with psychiatric services

Total psychiatric inpatient days _____

Total Medi-Cal psychiatric inpatient days _____

Reimbursement rate $ _____ Effective _____

Did you report this activity on Title V or XIX of CMS 2552-96 cost report form? ☐ Yes ☐ No

If yes, what cost center was it reported in? _____

Schedule 11
MEDI-CAL CREDIT BALANCE REPORT FOR INPATIENTS AND OUTPATIENTS**

Provider name				Provider number
Contact person	Telephone number ( )	Fiscal period ending	Provider number	Date prepared

Check one: ☐ Inpatient ☐ Outpatient

Beneficiary	Admission Date	Discharge Date	Paid Remittance Advice Date	(1) Amount of Credit Balance	(2) Amount Repaid and/or Retraction Requested	(3) CIFs* In Process	Medi-Cal Amount Outstanding Column 1 less Columns 2 and 3	Reason for Credit Balance
Totals	N/A	N/A	N/A	$	$	$	$***	N/A

* Subtract CIFs in process that are less than one year old.

** Submit a separate report for each provider number, and for the CMSP program which requires it's own report.

*** The reported outstanding Medi-Cal credit balances will be examined at the time of the audit for final settlement instead of at the time of cost report submission. Collection will be done in conjunction with the cost report audit.