

V Definitions

- A Base cost report. Desk-reviewed Medicare/Medicaid cost report. When a facility has more than one (1) cost report with periods ending in the fourth prior calendar year, the cost report covering a full twelve (12)-month period will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period will be used. If a hospital's base cost report is less than or greater than a twelve (12)-month period, the data shall be adjusted, based on the number of months reflected in the base cost report to a twelve (12)-month period.
- B Cost report. A cost report details, for purposes of both Medicare and Medicaid reimbursement, the cost of rendering covered services for the fiscal reporting period. The Medicare/Medicaid Uniform Cost Report contains the forms utilized in filing the cost report. The Medicare/ Medicaid Cost Report version 2552-96 (CMS 2552-96) shall be used for fiscal years ending on or after September 30, 1996. The Medicare/Medicaid Cost Report version 2552-10 (CMS 2552-10) shall be used for fiscal years beginning on and after May 1, 2010.
- C Effective date.
1. The plan effective date shall be July 1, 2002.
 2. New prospective outpatient payment percentages will be effective July 1 of each SFY.
- D Nominal charge provider. A nominal charge provider is determined from the fourth (4th) prior year desk reviewed cost report. The hospital must meet the following criteria:
1. An acute care hospital with an unsponsored care ratio of at least sixty-five percent (65%) and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of more than forty percent (40%). The unsponsored care ratio is determined as the sum of bad debts and charity care divided by total net revenue. The hospital must meet one of the federally mandated Disproportionate Share qualifications; or
 2. A public non-state governmental acute care hospital with a low income utilization rate (LIUR) of at least fifty percent (50%) and a Medicaid inpatient utilization rate (MIUR) greater than one standard deviation from the mean, and is licensed for fifty (50) inpatient beds or more and has an occupancy rate of at least forty percent (40%). The hospital must meet one (1) of the federally mandated Disproportionate Share qualifications; or
 3. The hospital is a public hospital operated by the Department of Mental Health primarily for the care and treatment of mental disorders.