# Ohio Revised Code

## Section 5168.01 Hospital care assurance program definitions.

Effective: September 29, 2013
Legislation: House Bill 59 - 130th General Assembly

As used in sections 5168.01 to 5168.14 of the Revised Code:

(A) "Bad debt," "charity care," "courtesy care," and "contractual allowances" have the same meanings given these terms in regulations adopted under Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(B) "Cost reporting period" means the twelve-month period used by a hospital in reporting costs for purposes of Title XVIII of the "Social Security Act," 42 U.S.C. 1395 et seq.

(C) "Disproportionate share hospital" means a hospital that meets the definition of a disproportionate share hospital in rules adopted under section 5168.02 of the Revised Code.

(D) "Federal poverty line" means the official poverty line defined by the United States office of management and budget based on the most recent data available from the United States bureau of the census and revised by the United States secretary of health and human services pursuant to the "Omnibus Budget Reconciliation Act of 1981," section 673(2), 42 U.S.C. 9902(2).

(E) "Governmental hospital" means a county hospital with more than five hundred registered beds or a state-owned and -operated hospital with more than five hundred registered beds.

(F)(1) "Hospital" means a nonfederal hospital to which either of the following applies:

(a) The hospital is registered under section 3701.07 of the Revised Code as a general medical and surgical hospital or a pediatric general hospital, and provides inpatient hospital services, as defined in 42 C.F.R. 440.10;

(b) The hospital is recognized under the medicare program as a cancer hospital and is exempt from the medicare prospective payment system.

(2) "Hospital" does not include a hospital operated by a health insuring corporation that has been issued a certificate of authority under section 1751.05 of the Revised Code or a hospital that does not charge patients for services.

(G) "Indigent care pool" means the sum of the following:

(1) The total of assessments to be paid in a program year by all hospitals under section 5168.06 of the Revised Code, less the assessments deposited into the legislative budget services fund under section 5168.12 of the Revised Code and into the health care services administration fund created under section 5162.54 of the Revised Code;

(2) The total amount of intergovernmental transfers required to be made in the same program year by governmental hospitals under section 5168.07 of the Revised Code, less the amount of transfers deposited into the legislative budget services fund under section 5168.12 of the Revised Code and into the health care services administration fund created under section 5162.54 of the Revised Code;

(3) The total amount of federal matching funds that will be made available in the same program year as a result of funds distributed by the department of medicaid to hospitals under section 5168.09 of the Revised Code.

(H) "Intergovernmental transfer" means any transfer of money by a governmental hospital under section 5168.07 of the Revised Code.

(I) "Medicaid services" has the same meaning as in section 5164.01 of the Revised Code.

(J) "Program year" means a period beginning the first day of October, or a later date designated in rules adopted under section 5168.02 of the Revised Code, and ending the thirtieth day of September, or an earlier date designated in rules adopted under that section.

(K) "Registered beds" means the total number of hospital beds registered with the department of health, as reported in the most recent "directory of registered hospitals" published by the

department of health.

(L) "Third-party payer" means any person or government entity that may be liable by law or contract to make payment to or on behalf of an individual for health care services. "Third-party payer" does not include a hospital.

(M) "Total facility costs" means the total costs for all services rendered to all patients, including the direct, indirect, and overhead cost to the hospital of all services, supplies, equipment, and capital related to the care of patients, regardless of whether patients are enrolled in a health insuring corporation, excluding costs associated with providing skilled nursing services in distinct-part nursing facility units, as shown on the hospital's cost report filed under section 5168.05 of the Revised Code. Effective October 1, 1993, if rules adopted under section 5168.02 of the Revised Code so provide, "total facility costs" may exclude costs associated with providing care to recipients of any of the governmental programs listed in division (B) of that section.

(N) "Uncompensated care" means bad debt and charity care.