

3620. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

This worksheet consists of five parts:

- Part I - Computation of Ratio of Cost to Charges
- Part II - Computation of Outpatient Services Cost to Charge Ratios Net of Reductions
- Part III - Computation of Total Inpatient Ancillary Costs - Rural Primary Care Hospitals
- Part IV - Computation of Inpatient Operating Costs - Rural Primary Care Hospitals
- Part V - Computation of Outpatient Cost Per Visit - Rural Primary Care Hospitals

NOTE: Rural primary care designation is replaced with critical access hospital beginning October 1, 1997. For cost reporting periods beginning after October 1, 1997, Parts III through V are not applicable.

3620.1 Part I - Computation of Ratio of Cost to Charges.--This worksheet computes the ratio of cost to charges for inpatient services and, for providers not subject to the outpatient capital reduction, the outpatient ratio of cost to charges. All charges entered on this worksheet must comply with PRM-I, sections 2202.4 and 2203. This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII costs not subject to the outpatient capital reduction; Worksheet D-4; Worksheet D-6; Worksheet H-4, Part II; and Worksheet J-2, Part II, to determine the program's share of ancillary service costs in accordance with 42 CFR 413.53. This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as PPS, TEFRA, or other.

42 CFR 413.106(f)(4) provides that the costs of therapy services furnished under arrangements to a hospital inpatient are exempt from the guidelines for physical therapy and respiratory therapy if such costs are subject to the provisions of 42 CFR 413.40 (rate of increase ceiling) or 42 CFR Part 412 (prospective payment).

42 CFR 405.482(a)(2) provides that RCE limits do not apply to the costs of physician compensation attributable to furnishing inpatient hospital services (provider component) paid for under 42 CFR Part 412ff.

To facilitate the cost finding methodology, apply the therapy limits and RCE limits to total departmental costs. This worksheet provides the mechanism for adjusting the costs after cost finding to comply with 42 CFR 413.106(f)(4) and 42 CFR 405.482(a)(2). This is done by computing a series of ratios in columns 9 through 11. In column 9, a ratio referred to as the "cost or other ratio" is computed based on the ratio of total reasonable cost to total charges. This ratio is used by you or your components not subject to PPS or TEFRA (e.g., hospital-based SNFs). Also use this ratio for Part B services still subject to cost reimbursement but not subject to outpatient capital reduction. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of RT/PT limitations to total cost since TEFRA inpatient costs are not subject to these limits. (TEFRA inpatient services are subject to RCE limits.) In column 11, compute a PPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by PPS are not subject to any of these limitations.

Column Descriptions

The following provider components may be subject to 42 CFR 413.40 or 42 CFR 412.1(a)ff:

- o Hospital Part A inpatient services for title XVIII,
- o Hospital subprovider Part A inpatient services for title XVIII,
- o Hospital inpatient services for titles V and XIX, and
- o Hospital subprovider services for titles V and XIX.

All components or portions of components not subject to PPS or TEFRA, e.g., outpatient services costs not subject to outpatient capital reduction, are classified as "Cost or Other."

The following matrix summarizes the columns completed for Cost or Other, TEFRA Inpatient, and PPS Inpatient:

<u>Type of Service</u>	<u>Columns</u>		
	<u>Cost or Other</u>	<u>TEFRA Inpatient</u>	<u>PPS Inpatient</u>
Inpatient routine service cost centers (lines 25-36)	1	1-3	1-5
Inpatient ancillary (lines 37-68)	1, 8, 9	1-3, 8-10	1-9, 11
Outpatient ancillary and outpatient cost centers (for costs not subject to capital reduction)	1, 8, 9	1-3, 8-10	1-9, 11

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. Transfer the amount on line 62 from Worksheet D-1, Part IV, line 85, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 62 into line 62.01, and transfer the appropriate amount from Worksheet B, Part I, column 27. In a complex comprised of an acute care hospital with an excluded unit, the acute care hospital reports the observation bed costs. Subproviders (hospital only, i.e. psychiatric, rehabilitation, or long term care facility) with separate provider numbers from the main hospital may report observation bed costs if a separate outpatient department is maintained within the subprovider unit. If the subprovider is reporting observation bed days (Worksheet S-3, line 26.01), add the amount reported by both the hospital and the subprovider from Worksheet D-1, line 85, and enter the sum on line 62. The RHC/FQHC costs on lines 63.50 through 63.99, for cost reporting periods which overlap the January 1, 1998, effective date will be transferred to this worksheet from Worksheet B, column 27. For cost reporting periods beginning on or after January 1, 1998, no cost or charges are reported on this worksheet for the RHC/FQHC. However, any services provided by the RHC/FQHC outside the benefits package for those clinics are reported by the hospital in its appropriate ancillary cost center, but not in the RHC/FQHC cost center lines 63.50 through 63.99 (1/98). Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in column 6 of the appropriate line on Worksheet C, Part I.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 49 to 52. Obtain these amounts from Worksheet A-8, lines 25, 26, 35 and 36 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS (see 42 CFR 412.1(a) through 412.125) or the TEFRA rate of increase ceiling. (See 42 CFR 413.40.) If the hospital and all subproviders have correctly indicated that their payment system is in the "other" category on Worksheet S-2, do not complete columns 2 through 5, 10, and 11.

Column 3--Enter on each cost center line the sum of columns 1 and 2.

Column 4--Only complete this section if you or your subproviders are subject to PPS. Enter on each line the amount of the RCE disallowance. Obtain these amounts from the sum of the amounts for the corresponding line on Worksheet A-8-2, column 17.

Column 5--Complete this section only if you or your subproviders are subject to PPS. Enter on each cost center line the sum of the amounts entered in columns 3 and 4.

Columns 6 and 7--Enter on each cost center line the total inpatient and outpatient gross patient charges including charity care for that cost center. Include in the appropriate cost centers items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). DME, oxygen, and orthotic and prosthetic devices (except for enteral and parental nutrients and intraocular lenses furnished by providers) are paid by the Part B carrier or the regional home health intermediary on the basis of the lower of the supplier's actual charge or a fee schedule. Therefore, do not include Medicare charges applicable to these items in the Medicare charges reported on Worksheet D-4 and Worksheet D, Part V. However, include your standard customary charges for these items in total charges reported on Worksheet C, Part I. This is necessary to avoid the need to split your organizational cost centers such as medical supplies between those items paid on a fee basis and those items subject to cost reimbursement.

NOTE: For line 60, any ancillary service billed as clinic services must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, PBP clinical lab services - program only. A similar adjustment must be made to program charges.

Enter on line 62 all observation bed charges for observation beds not set up as a separate unit. These charges relate to all payer classes and include those observation bed charges for patients released as outpatients and those patients admitted as inpatients. If you have a distinct observation unit, report your gross charges on line 62.01 (which was subscribed on Worksheet A). If observation bed costs are also provided by a subprovider (no alpha character in the provider number), combine the charges for purposes of calculating the cost to charge ratio.

If the total charges for all patients for a department include a charge for the provider-based physician's professional component, then total and program charges used on Worksheets D, D-2, D-4, and D-6 must also include the PBP's professional component charge in order to correctly apportion costs to the program. Similarly, when total charges on Worksheet C, Part I, for a department are for provider services only, charges on Worksheets D, D-2, D-4, and D-6 must also include provider services only.

When reporting charges for a complex, e.g., hospital, subprovider, SNF, charges for like services must be uniform. (See HCFA Pub. 15-I, §§2203 and 2314 for the exception dealing with grossing up of charges.)

When certain services are furnished under arrangements and an adjustment is made on Worksheet A-8 to gross up costs, gross up the related charges entered on Worksheet C, Part I, in accordance with HCFA Pub. 15-I, §2314. If no adjustment is made on Worksheet A-8, show only the charges you actually billed on Worksheet C, Part I.

NOTE: Any cost center that includes CRNA charges must exclude these charges unless the hospital qualifies for the rural exception as outlined in §3610. All cost centers for which CRNA costs are excluded on Worksheet A-8 must also exclude the charges associated with these costs.

Column 8--Enter the total of columns 6 and 7.

Column 9--Always complete this column. Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8 to determine the ratio of total cost to total charges (referred to as the "Cost or Other" ratio) for that cost center. Enter the resultant departmental ratios in this column. Round ratios to 6 decimal places.

Column 10--Complete this section only when the hospital or its subprovider is subject to the

TEFRA rate of increase ceiling. (See 42 CFR 413.40.) Divide the amount reported in column 3 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RT/PT adjusted ratio of cost to charges (referred to as the TEFRA inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Column 11--Complete this section only when the hospital or its subprovider is subject to PPS. (See 42 CFR 412.1(a) through 412.125.) Divide the amount reported in column 5 (which represents the total cost adjusted for the add-back of amounts excluded on Worksheet A-8 for the RT/PT and the RCE limits) for each cost center by the total charges for the cost center in column 8.

This computation determines the RCE/RT/PT adjusted ratio of cost to charges (referred to as the PPS inpatient ratio) for each cost center. Enter the resultant departmental ratio. Round ratios to 6 decimal places.

Line Descriptions

Lines 25 through 68--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, and B-1. This design facilitates referencing throughout the cost report. Therefore, if you have subscribed any lines on those worksheets, you must subscribe the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 25 because of this referencing feature.

Line 102--Enter the amounts from line 62. Calculate the observation bed cost on line 62 using the routine cost per diem from Worksheet D-1 because it is part of routine costs and as such has been included in the amounts reported on line 25 for the hospital or line 31 in the case of a subprovider. Therefore, in order to arrive at the total allowable costs, subtract this cost to avoid reporting these costs twice.

Line 103--For each column, subtract line 102 from line 101, and enter the result.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, the total charges on line 101 are overstated by the amount on line 45.

Transfer Referencing

Costs--The costs of the inpatient routine service cost centers are transferred:

From Worksheet C, Part I
(Columns 1, 3, or 5)

To

Line 25	Wkst. D-1, Part I, Line 21
Lines 26 - 30	Wkst. D-1, Part II, Lines 43-47
Line 31 and subscripts	Separate Wkst. D-1, Part I, Line 21
Line 33 (titles V and XIX only)	Wkst. D-1, Part II, Line 42
Line 34 (title XVIII only)	Separate Wkst. D-1, Part I, Line 21
Line 35 and subscripts (titles V and XIX only)	Separate Wkst. D-1, Part I, Line 21

Charges--Transfer the total charges for each of lines 37 through 68, column 8, to Worksheet C, Part II, column 7, and Worksheet D, Part IV, column 6, lines as appropriate.

Ratios

Cost or Other Ratios--The "Cost or Other" ratio is transferred from column 9:

<u>For</u>	<u>To</u>
Hospital, subprovider, SNF, NF, swing bed-SNF, and swing bed-NF:	
1. Inpatient ancillary services for titles V, XVIII, Part A, and XIX	Wkst. D-4, column 1, for each cost center
Ancillary services furnished by the hospital-based HHA	Wkst. H-6, Part II, column 1, line as appropriate
Hospital-based CORF, CMHC, or OPT/OOT/OSP shared ancillary services for titles V, XVIII, Part B, and XIX	Wkst. J-2, Part II, column 3, line as appropriate

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 37 through 64 and 66 through 68 from column 10 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) to Worksheet D-4, column 1 for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 37 through 64 and 66 through 68 from column 11 for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to PPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-4, column 1 for each cost center.

3620.2 Part II - Calculation of Outpatient Services Cost to Charge Ratios Net of Reductions.--This worksheet computes the outpatient cost to charge ratios reflecting the following: (Do not complete this section for cost reporting periods beginning on or after August 1, 2000.)

o The reduction in hospital outpatient capital payments attributable to portions of cost reporting periods occurring from October 1, 1989 through September 30, 1998, as required by §1861(v)(1)(S)(ii) of the Act. The amount of capital reduction is 10 percent for payments for services rendered from October 1, 1991 through July 31, 2000.

o The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services) attributable to portions of cost reporting periods occurring from October 1, 1990 through September 30, 1998, as required by §1861(v)(1)(S)(ii) of the Act and enacted by §4151(b) of OBRA 1990. The amount of the reduction is 5.8 percent for payments for services rendered on or after October 1, 1990 through July 31, 2000. The reduction does not apply to inpatient services paid under Part B of the program (10/90).

The reductions do not apply to sole community hospitals (SCH), rural primary care hospitals (RPCH)/Critical Access Hospitals (CAH). However, if you have been granted SCH status or have ended SCH status during this cost reporting period, calculate the reductions for the periods during which time your hospital was not granted SCH status during your cost reporting year (i.e., compute the reduction percentage by dividing the number of days in your cost reporting period to which the reductions applied (and during which you were not a SCH) by the total number of days in the cost reporting period. Multiply that ratio by the applicable percentage. The result is the applicable outpatient reduction percentage). Titles V and XIX follow their state plan in determining the applicable outpatient cost to charge ratios.

NOTE: For cost reporting periods beginning before August 1, 2000, if the RPCH/CAH is a complex which has subproviders, Worksheet C, Part II must be completed to accommodate the RPCH/CAH's subproviders.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 27, as appropriate. Transfer the amount on line 62 from Worksheet D-1, line 85 for the hospital and the subprovider if applicable and if you use inpatient routine beds as observation beds (10/00). If you have a distinct observation bed area, add subscripted line 62.01 and transfer the appropriate amount from Worksheet B, Part I, column 27. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 27.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Parts II and III, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, Worksheet B, Part II, or Worksheet B, Part III. For line 62, enter the amounts from Worksheet D-1, Part IV, column 5, sum of lines 86 and 87. Combine the hospital and subprovider amounts if applicable.

Column 3--For each line, subtract column 2 from column 1, and enter the result.

Column 4--Multiply column 2 by the appropriate capital reduction percentage, and enter the result.

Column 5--Multiply column 3 by the outpatient reasonable cost reduction percentage, and enter the result.

Column 6--Subtract columns 4 and 5 from column 1, and enter the result.

Column 7--Enter the total charges from Worksheet C, Part I, column 8.

Column 8--Divide column 6 by column 7, and enter the result.

Column 9--Enter the cost to charge ratio required for hospital inpatient part B exempt from the 5.8 percent reduction. That percentage is equal to column 1 minus column 4 and that result divided by the amount from column 7.

3620.3 Part III - Computation of Total Inpatient Ancillary Costs - Rural Primary Care Hospitals--This worksheet computes the total inpatient ancillary cost for rural primary care hospitals. This worksheet is not applicable for cost reporting periods beginning after October 1, 1997. CAHs replaced RPCHs and are reimbursed on reasonable cost based on a combined per diem of routine and ancillary costs.

Column Descriptions

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. The amount reported on line 62 is transferred from Worksheet D-1, line 85. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in columns 2 and 3 of the appropriate lines on Worksheet C, Part III.

Column 2--Enter on each cost center line the total gross patient charges, including charity care for that cost center, from Worksheet C, Part I, column 8. If the total charges in column 2 include charges for physician services, the charges in column 3 must also include physician charges.

Column 3--Enter on each cost center line the appropriate inpatient hospital ancillary departmental charges. Do not include charges from other provider based activities. If the charges in column 2 included charges billed for physician services for Medicare and non-Medicare patients, also include these charges for physician services in column 3.

Column 4--Always complete this column. Divide the total inpatient charges in column 3 by the total ancillary charges in column 2 to arrive at the percentage of inpatient charges to total charges. Enter the resultant departmental ratios. Round the ratios to 6 decimal places.

Column 5--Multiply the ratio calculated in column 4 by the total costs reported in column 1 for each cost center.

Line Descriptions

Lines 37 through 68--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report. Therefore, if you have subscribed lines on those worksheets, you must subscribe the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 37 because of this referencing feature.

Transfer the amount from column 5, line 101, to Worksheet C, Part IV, line 2.

3620.4 Part IV - Computation of Inpatient Operating Costs - Rural Primary Care Hospitals--This worksheet provides for the computation of hospital inpatient operating cost for rural primary care hospitals. This worksheet is not applicable for cost reporting periods beginning after October 1, 1997. CAHs replaced RPCHs and are reimbursed on the basis of reasonable cost based on a combined per diem of routine and ancillary costs.

Lines 1 through 5--Complete lines 1 through 4 for the initial 12-month period of operation only. For subsequent periods, enter on line 5 the cost per diem from the previous cost reporting period, multiplied by the market basket percentage increase under §1886(b)(3)(B)(I) of the Act for the period applicable to hospitals located in rural areas.

Line 1--Enter the adjusted general inpatient routine service cost net of swing bed-SNF type service cost from Worksheet D-1, line 37, reduced by the amount reported on Worksheet C, Part III, column 1, line 62.

Line 2--Enter the total inpatient ancillary service cost from Worksheet C, Part III, column 5, line 101.

Line 3--Enter the sum of lines 1 and 2.

Line 4--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Obtain this amount from Worksheet S-3, Part I, column 6, line 1.

Line 5--For the initial 12-month period of operation, enter the amount on line 3, divided by line 4, rounded to 2 decimal places. For subsequent periods, enter the cost per diem from the previous cost reporting period, multiplied by the market basket percentage increase under §1886(b)(3)(B)(I) of the Act for the period applicable to hospitals located in rural areas.

Line 6--Enter the program inpatient RPCH service cost in the applicable column. This amount is computed as the amount on line 5, multiplied by the amount on Worksheet D-1, line 9 for each title. Transfer this amount to Worksheet E-3, Part II, line 1, for title XVIII, and Part III, column 1, line 1, for titles V and XIX.

Line 7--Enter the amount of Medicare swing bed-SNF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on Worksheet D-1, line 10, by the rate used on Worksheet D-1, line 17. For titles V and XIX, multiply line 12 by line 19.

Line 8--Enter the amount of Medicare swing bed-SNF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-SNF type inpatient days on Worksheet D-1, line 11, by the rate used on Worksheet D-1, line 18. For titles V and XIX, multiply line 13 by line 20.

Line 9--Enter the sum of lines 7 and 8. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1, for title XVIII and Worksheet E-2, column 1, line 2, for titles V and XIX.

3620.5 Part V - Computation of Outpatient Cost Per Visit - Rural Primary Care Hospitals--This worksheet calculates the outpatient cost per visit for rural primary care hospitals electing to be paid for outpatient services on a combined basis with provider-based physicians. (This worksheet is not applicable for cost reporting periods beginning after October 1, 1997. RPCHs are replaced by CAHs) This worksheet is completed for each applicable title.

Column Descriptions

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 27. The amount reported on line 62 is transferred from Worksheet D-1, line 85. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 27. However, report the charges applicable to such cost centers with a credit balance in columns 4 and 5 of the appropriate line on Worksheet C, Part IV.

Column 2--Enter on each line the appropriate amount of provider-based physician compensation previously adjusted out on Worksheet A-8 which can be traced to Worksheet A-8-2 for each ancillary department. To qualify for the all-inclusive rate, all health professionals must have a compensation agreement with the RPCH. The health professionals' actual time is divided among inpatient services, outpatient services, and non-allowable activities such as research.

Column 3--Enter on each cost center line the sum of columns 1 and 2.

Column 4--Enter on each cost center line the appropriate total ancillary departmental charges which includes the charge billed for physician services for Medicare and non-Medicare patients from Worksheet C, Part III, column 2, lines as applicable.

Column 5--Enter on each cost center line the appropriate total outpatient ancillary charges by department including the charges for physician services.

Column 6--Always complete this column. Divide the total outpatient charges in column 5 by the total ancillary charges in column 4 to arrive at the percentage of outpatient charges to total charges. Enter the resultant departmental ratios. Round the ratios to 6 decimal places.

Column 7--Multiply the ratio calculated in column 6 by the total costs reported in column 3 for each cost center.

Line Descriptions

Lines 37 through 68--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report. Therefore, if you have subscripted lines on those worksheets, you must subscript the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 37 because of this referencing feature.

Line 62--Enter the amount calculated on Worksheet D-1, Part IV, line 85, for observation bed cost applicable to outpatient.

Line 102--Enter total outpatient visits from Worksheet S-3, Part I, column 6, line 13.

Line 103--Divide line 101 by line 102, and enter the result.

Line 104--Enter title V program visits from Worksheet S-3, Part I, column 3, line 13.

Line 105--Enter title XVIII program visits from Worksheet S-3, Part I, column 4, line 13.

Line 106--Enter title XIX program visits from Worksheet S-3, Part I, column 5, line 13.

Line 107--For title V, multiply line 104 by line 103. Transfer this amount to Worksheet E-3, Part III, line 2.

Line 108--For title XVIII, multiply line 105 by line 103. Transfer this amount to Worksheet E, Part B, line 1.

Line 109--For title XIX, multiply line 106 by line 103. Transfer this amount to Worksheet E-3, Part III, line 2.