

3621. WORKSHEET D - COST APPORTIONMENT

Worksheet D consists of the following six parts:

- Part I - Apportionment of Inpatient Routine Service Capital Costs
- Part II - Apportionment of Inpatient Ancillary Service Capital Costs
- Part III - Apportionment of Inpatient Routine Service Other Pass Through Costs
- Part IV - Apportionment of Inpatient Ancillary Service Other Pass Through Costs
- Part V - Apportionment of Medical and Other Health Services Costs
- Part VI - Vaccine Cost Apportionment

At the top of each part, indicate by checking the appropriate boxes the health care program, provider component, and the payment system, as applicable, for which the part is prepared.

NOTE: Only hospital components subject to PPS or TEFRA complete Worksheet D, Parts I through IV. For cost reporting periods beginning on or after July 1, 1998, the hospital based SNF and NF providers have been added to the D, Part III and will also complete a separate Worksheet D, Part IV.

Line Descriptions for Parts I Through V

Lines 25 through 33 (for Parts I and III) and line 34 (for Part III) and 37 through 68 (for Parts II, IV, and V).--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.

3621.1 Part I - Apportionment of Inpatient Routine Service Capital Costs.--This part computes the amount of capital-related costs applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part I, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate. Complete this part for all payment methods.

Column 1--Enter on each line the old capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 27.

Column 2--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the amounts in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, line 21.

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

Column 4--Enter on each line the new capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part III, column 27.

Column 5--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the amounts in column 4 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, line 21.

Column 6--For each line, enter the results of subtracting column 5 from column 4.

Column 7--Enter on each line the total patient days, excluding swing bed days, for that cost center. For line 25, enter the total days reported on Worksheet S-3, Part I, column 6, the sum of lines 1 and 26. For lines 26 through 33, enter the days from Worksheet S-3, Part I, column 6, lines 6 through 10, 14, and 11 respectively. For subprovider, line 31, add to line 14 of worksheet S-3, the observation bed days, if applicable, reported on the subscripts of line 26.

Column 8--Enter the program inpatient days for the applicable cost centers. For line 25, enter the days reported on Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, line 1. For lines 26 through 33, enter the days from Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, lines 6 through 10, 14, and 11, respectively.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-I, §2217.) Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit to line 25, and decrease the appropriate intensive care or other special care unit by those days.

Column 9--Divide the old capital costs of each cost center in column 3 by the total patient days in column 7 for each line to determine the old capital per diem cost. Enter the resultant per diem cost in column 9.

Column 10--Multiply the per diem in column 9 by the inpatient program days in column 8 to determine the program's share of old capital costs applicable to inpatient routine services, as applicable.

Column 11--Divide the new capital costs of each cost center in column 6 by the total patient days in column 7 for each line to determine the new capital per diem cost. Enter the resultant per diem cost in column 11.

Column 12--Multiply the per diem in column 11 by the inpatient program days in column 8 to determine the program's share of new capital costs applicable to inpatient routine services, as applicable.

3621.2 Part II - Apportionment of Inpatient Ancillary Service Capital Costs--This worksheet is provided to compute the amount of capital costs applicable to hospital inpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 27.

Column 1--Enter on each line the old capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 27. For the hospital component or subprovider, if applicable, enter on line 62 the amount from Worksheet D-1, Part IV, column 5, line 86.

Column 2--Enter on each line the new capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part III, column 27. For the hospital and subprovider components only, enter on line 62 the sum of the hospital and subprovider amounts from Worksheet D-1, Part IV, column 5, line 87.

Column 3--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 4--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-4, column 2. Enter on line 62 the title XVIII observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 66 the Medicare charges for medical equipment rented by an inpatient. The charges are reimbursed under the DRG. However, you are entitled to the capital-related cost pass through applicable to this medical equipment.

NOTE: Program charges for PPS providers are reported in the cost reporting period in which the discharge is reported. TEFRA providers report charges in the cost reporting period in which they occur.

Do not include in Medicare charges any charges identified as MSP/LCC.

Column 5--Divide the old capital cost of each cost center in column 1 by the charges in column 3 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 5.

Column 6--Multiply the old capital ratio in column 5 by the program charges in column 4 to determine the program's share of old capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

Column 7--Divide the new capital cost of each cost center in column 2 by the charges in column 3 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 7.

Column 8--Multiply the new capital ratio in column 7 by the program charges in column 4 to determine the program's share of new capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

3621.3 Part III - Apportionment of Inpatient Routine Service Other Pass Through Costs--This part computes the amount of pass through costs other than capital applicable to hospital inpatient routine service costs. Determine capital-related inpatient routine service costs on Worksheet D, Part I. Complete only one Worksheet D, Part III for each title. Report hospital, subprovider, SNF and NF/ICFMR (if applicable) information on the same worksheet, lines as appropriate. For cost reporting periods beginning on or after July 1, 1998, SNFs are required to report medical education costs as a pass through cost.

Column 1--For PPS hospitals and components which qualify for the exception to the implementation of the CRNA fee schedule, enter on each line the nonphysician anesthetist cost for each cost center, as appropriate. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 after taking into consideration any post step down adjustments that may have been made after cost finding.

Column 2--Enter on each line (after taking into consideration any post step down adjustments applicable to direct medical education costs made after cost finding) the direct medical education cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part I, sum of columns 21 and 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to direct medical education costs for nursing school and paramedical education. For SNF/NFs enter the sum of columns 21 through 24 unless the hospital is receiving graduate medical education payments reported on worksheet E-3, Part IV (Worksheet S-2, line 25.02 with a yes response); then report the sum of columns 21 and 24 only.

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2 subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Column 3--Compute the amount of the swing bed adjustment. If you have a swing bed agreement or have elected the swing bed optional method of reimbursement, determine the amount for the cost center in which the swing beds are located by multiplying the sum of the amounts in columns 1 and 2 by the ratio of the amount entered on Worksheet D-1, line 26 to the amount entered on Worksheet D-1, line 21.

Column 4--Enter the sum of columns 1 and 2 minus column 3.

Column 5--Enter on each line the total patient days, excluding swing bed days, for that cost center. Transfer these amounts from the appropriate Worksheet D, Part I, column 7. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 6, line 15.

Column 6--Divide the cost of each cost center in column 4 by the total patient days in column 5 for each line to determine the pass through cost. Enter the resultant per diem cost in column 6.

Column 7--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 8. For SNF cost reporting periods beginning on or after July 1, 1998, enter the program days from worksheet S-3, Part I, column 4, line 15.

Column 8--Multiply the per diem cost in column 6 by the inpatient program days in column 7 to determine the program's share of pass through costs applicable to inpatient routine services, as applicable. Transfer the sum of the amounts on lines 25 through 30 and 33 to Worksheet D-1, line 50 for the hospital. Transfer the amount on line 31 to the appropriate Worksheet D-1, line 50 for the subprovider. If you are a title XVIII hospital or subprovider paid under PPS, also transfer these amounts to the appropriate Worksheet E, Part A, line 14. For SNF, NF or ICF/MR that follow Medicare principles for cost reporting periods beginning on or after July 1, 1998, transfer the amount on column 8, line 34 to Worksheet E-3, Part III, line 28.

3621.4 Part IV - Apportionment of Inpatient/Outpatient Ancillary Service Other Pass Through Costs--The TEFRA rate of increase limitation applies to inpatient operating costs. In order to determine inpatient operating costs, it is necessary to exclude capital-related and medical education costs as these costs are reimbursed separately. Hospitals and subprovider components subject to PPS must also exclude nonphysician anesthetist and direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. For cost reporting periods beginning on or after July 1, 1998, SNFs are required to report medical education costs as a pass through cost. Prepare a separate Worksheet D, Part IV for the SNF and NF/ICFMR (if applicable). Beginning August 1, 2000, hospital payment for outpatient services will be made prospectively with the exception of certain pass through costs identified on this worksheet.

This worksheet is provided to compute the amount of pass through costs other than capital applicable to hospital inpatient and outpatient ancillary services for titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider for titles V, XVIII, Part A, and XIX, as applicable. In this case, enter the subprovider component number in addition to showing the provider number.

Make no entries on this worksheet for any costs centers with a negative balance on Worksheet B, Part I, column 27.

Column 1--Enter on each line (after any adjustments made after cost finding) the nonphysician anesthetist cost for hospitals and components qualifying for the exception to the CRNA fee schedule. (See §3610, line 20 description for more information.) Obtain this amount from Worksheet B, Part I, column 20 plus or minus any adjustments reported on Worksheet B, Part I, column 26 for

nonphysician anesthetist. For the hospital and subprovider (if applicable) components only, enter on line 62, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 88.

Column 1.01--For cost reporting periods ending on or after 4/1/2003, column 1 will be subscripted. Column 1.01 will represent outpatient CRNA costs for hospitals and components qualifying for the exception to the CRNA fee schedule. For cost reporting periods that straddle April 1, 2003, prorate the amount in column 1 by the ratio of days prior to 4/1/2003 to total days in the cost reporting period. For cost reporting periods beginning on or after 4/1/2003 do not complete this column (enter zero).

Column 2--Enter on each line (after taking into consideration any adjustments made in column 26 of Worksheet B, Part I) the direct medical education costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part I, sum of columns 21 and 24 plus or minus post step down adjustments made on Worksheet B, Part I, column 26 applicable to direct medical education costs. For SNFs enter the sum of columns 21 through 24 unless the hospital is receiving graduate medical education payments reported on worksheet E-3, Part IV (Worksheet S-2, line 25.02 with a yes response); then report the sum of columns 21 and 24 only (7/98). For the hospital and subprovider (if applicable) components only, enter on line 62 the sum of the hospital and subprovider observation bed amounts from Worksheet D-1, Part IV, column 5, line 89.

NOTE: If you qualify for the exception in 42 CFR 413.86(e)(4), all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost. Enter the amount from Worksheet B, Part I, sum of columns 21 through 24 plus or minus post step down adjustments (reported on Worksheet B-2) applicable to medical education costs.

If you answered yes to question 57 on Worksheet S-2, subscript this column and report in column 2 nursing school, column 2.01 allied health costs (paramedical education) and column 2.02 all other medical education costs.

Enter the costs of administering blood clotting factors to hemophiliacs in column 2.03, line 46.30 from Worksheet B, column 27, subscript of line 46 containing the corresponding costs. Complete only columns 2.03 and 3 through 7 for this entry. (8/31/02) (see §4452 of BBA 1997)

Column 3--Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 and 2.

Column 3.01--For cost reporting periods ending on or after 4/1/2003, column 3 will be subscripted. Column 3.01 will represent outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1.01 and 2, including subscripts of column 2.

Column 4--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 5--Divide the cost of each cost center in column 3 by the charges in column 4 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 5.

Column 5.01--For cost reporting periods ending on or after 4/1/2003, column 5 will be subscripted. Divide the cost of each cost center in column 3.01 by the charges in column 4 for each line to determine the cost/charge ratio. Round the ratios to six decimal places, e.g., round .0321514 to .032151. Enter the resultant departmental ratio in column 5.01.

Column 6--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-4. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 7--Multiply the ratio in column 5 by the charges in column 6 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

Column 8--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 5.01, 5.03, and 5.04, if applicable. Do not include in Medicare charges any charges identified as MSP/LCC (8/00).

NOTE: Columns 8 and 9 will be subscripted to reflect to separate columns for worksheet D, Part V, columns 5.03 and 5.04, if applicable. (8/2000)

Column 9--Multiply the ratio in column 5 by the charges in column 8 to determine the program's share of pass through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate (8/00).

For hospitals and subproviders transfer column 7, line 101 to Worksheet D-1, Part II, column 1, line 51. If you are a PPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 15. For SNFs, NFs, and ICF/MRs for titles XVIII and XIX, for cost reporting periods beginning on or after July 1, 1998, transfer the amount on line 101 to Worksheet E-3, Part III, line 29 (7/98).

Column 9 (and subscripts)--For cost reporting periods ending prior to 4/1/2003, multiply the ratio in column 5 by the charges in column 8 (and subscripts). For cost reporting periods ending on or after 4/1/2003, multiply the ratio in column 5.01 by the charges in Column 8 (and subscripts).

3621.5 Part V - Apportionment of Medical and Other Health Services Costs--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX, as well as inpatient services reimbursable under title XVIII, Part B. Title XVIII is reimbursed in accordance with 42 CFR 413.53. Do not complete this worksheet for an RPCH component that has elected the all-inclusive payment method for outpatient services. (See Worksheet S-2, lines 30 through 30.02.) Payment under the all-inclusive payment method for outpatient services is computed on Worksheet C, Part V. Critical access hospitals do not complete columns 2 through 4 and 6 through 8 of this worksheet. Providers exempt from outpatient PPS (i.e., SNFs, CAHs, & swing bed SNFs), complete columns 5 and 9. All other providers subscript columns 5 and 9 as necessary.

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report those charges on Worksheet J-2.

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 6 through 9 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 27. However, complete columns 2 through 5 for such cost centers.

For cost reporting periods that end on or after October 1, 1997, and before September 30, 1998, subscript columns 2 through 4 and 6 through 8 and report the charges and cost during the period for services prior to October 1, 1997, in columns 2 through 4 and 6 through 8 and report the charges and costs for the periods on or after October 1, 1997, and before September 30, 1998 in columns 2.01 through 4.01 and 6.01 through 8.01. The subscripting is required as a result of the change in

calculating the different payment methodologies on Worksheet E, Parts C, D, and E regarding the application of deductibles and coinsurance. Subscribing is not required for cost reporting periods ending on or after September 30, 1998. Revert back to reporting the charges and costs for these services in columns 2 through 4 and 6 through 8. For services rendered on and after August 1, 2000, outpatient services are subject to prospective payment. For cost reporting periods that overlap the effective date, subscript the columns to accommodate the proper reporting of cost reimbursement prior to August 1, 2000, and prospective payment on and after August 1, 2000.

Columns 1, 1.01 and 1.02--Enter on each line in column 1 and 1.02, for hospital and subprovider components, the ratio from the corresponding line on Worksheet C, Part II, columns 8 and 9, respectively, for services rendered prior to August 1, 2000. For SCH (full cost reporting period), RPCH/CAH, SNF, NF, and swing bed services, enter on each line in column 1 the ratio from the corresponding line on Worksheet C, Part I, column 9. Enter in column 1.01 the ratio from the corresponding line on Worksheet C, Part I, column 9 for services on and after August 1, 2000.

Columns 2 and 2.01--Enter on the appropriate line the charges (per your records or the PS&R ASC segment) for outpatient ambulatory surgical services through July 31, 2000.

Columns 3 and 3.01--Enter on the appropriate line the outpatient radiology charges per your records or the PS&R outpatient radiology segment through July 31, 2000.

Columns 4 and 4.01--Enter on the appropriate line the other outpatient diagnostic procedure charges per your records or the PS&R other diagnostic segment through July 31, 2000.

Columns 5, 5.01 and 5.02--For title XVIII, enter the charges for outpatient services not included in any other column in Part V. For SNFs for services rendered which overlap the effective date of January 1, 1998, for physical, occupational and speech therapy (lines 50 through 52) subscript this column and report charges before January 1, 1998, in column 5 and on and after January 1, 1998, in column 5.01. Subscripting is not required for cost reporting periods beginning on or after January 1, 1998. For hospitals claiming ambulance services for cost reporting periods which overlap October 1, 1997, subscript column 5. Enter on line 65, column 5 the charges relating to the period on or after October 1, 1997, and in column 5.01 the charges relating to prior to October 1, 1997. For cost reporting periods beginning on or after October 1, 1997, do not complete column 5.01 for ambulance. Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges. Do not include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis. These charges are reported on Worksheet D, Part VI. Do not include in Medicare charges any charges identified as MSP/LCC. Effective August 1, 2000, enter in column 5 the services prior to August 1, 2000, paid based on cost. In column 5.01 enter the charges for services rendered on or after August 1, 2000, paid subject to the prospective payment system. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 5.03, 5.04) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. In column 5.02 enter the charges for services rendered on and after August 1, 2000, e.g., for drugs and supplies related to ESRD dialysis (excluding EPO, and any drugs or supplies paid under the composite rate), and corneal tissue. For cost reporting periods which overlap August 1, 2000, report ambulance service charges prior to August 1st, in column 5 and services on and after August 1st in column 5.02. Do not include in any column services excluded from OPSS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab. Hospitals with cost reporting periods which overlap August 1, 2000, report in columns 1.02 through 5 the applicable amounts for services render prior to August 1, 2000, report in column 5.01 the applicable PPS amounts for services on or after August 1, 2000, and report in column 5.02 the cost of services on or after August 1, 2000 which were erroneously paid at cost.

For cost reporting periods beginning on or after January 1, 1999, for SNF, CAHs, and title XIX services not paid under PPS no subscripting is required. Report all charges in column 5.

For CAHs (BIPA §205), enter the charges for the period you are subject to the limit and/or blend and the subscripted line the charges for which you are exempt from the limit and/or blend (see Worksheet S-2, line 30.03). If you are exempt for the full cost reporting period only complete line 65, no subscripts are required. *For CAHs with cost reporting periods beginning on or after October 1, 2009, complete line 65 only for ambulance services that were billed as exempt from the ambulance fee schedule (from your records or PS&R report type 85C).*

For cost reporting periods overlapping 4/1/2002 and after subscript line 65 for ambulance services in accordance with the subscripts on Worksheet S-2, line 56 and report charges separately on line 65 and subscripts for the applicable periods. Do not subscript line 65 for cost reporting periods beginning on or after 1/1/2006, as the ambulance PPS payment blend will transition to 100 percent fee based payments and do not report charges for ambulance services rendered on or after January 1, 2006.

Columns 6 and 6.01--Multiply the charges in column 2 and 2.01 by the ratios in column 1, and enter the result. Line 101 equals the sum of lines 37 through 68.

Columns 7 and 7.01--Multiply the charges in column 3 and 3.01 by the ratios in column 1, and enter the result.

Columns 8 and 8.01--Multiply the charges in column 4 and 4.01 by the ratios in column 1, and enter the result.

Columns 9, 9.01, and 9.02--Multiply the charges in column 5 by the ratios in column 1, and enter the result. For hospitals subject to outpatient prospective payment, multiply the charges in column 5.01 and 5.02, or any additional subscripted column of column 5 by the ratios in column 1.01, and enter the result in columns 9.01 and 9.02 or additional subscripts, respectively. For SNFs subscript this column and report the result of multiplying the ratio in column 1 by the charges in columns 5 and 5.01 for physical and occupational therapies, and speech pathology. For lines 50 through 52 only, for services rendered on and after January 1, 1998, enter in column 9.01, 90 percent of the result of multiplying the ratio in column 1 by the charges in column 5.01. For SNF services rendered on and after January 1, 1999, make no entry for therapy services paid under a fee schedule for lines 50 through 52. The amount entered on line 65 of this column, Ambulance, for all providers, cannot exceed the payment limit calculated from Worksheet S-2, column 2, lines 56 and 56.01 (if applicable), times the amount on Worksheet S-3, Part I, column 4, line 27 and 27.01 (if applicable) respectively, for ambulance services on or after October 1, 1997. For cost reporting periods which overlap the October 1, 1997, effective date, enter in column 9 the lower of the cost (column 1 times column 5, rounded to zero, or the limit (Worksheet S-2, Column 2, line 56, times, Worksheet S-3, Part I, column 4, line 27, rounded to zero), added to column 1 times column 5.01 rounded to zero). Hospitals with cost reporting periods that overlap August 1, 2000, subscript column 9 in accordance with column 5 instructions.

For cost reporting periods beginning on or after October 1, 1997, costs for ambulance services are calculated from column 5 charges only. For cost reporting periods which overlap August 1, 2000, to calculate the ambulance costs, multiply the charges reported in column 5 by the appropriate ratio in column 1 and multiply the charges reported in columns 5.01 by the appropriate ratio in column 1.01 and add the results. Compare that to the limit amount calculated as indicated above and enter the lesser of the two in column 9.02.

Ambulance services on or after 4/1/2002 through 12/31/2005 are reimbursed on a blend of the lesser of the cost (the lesser of the cost to charge ratio times charges or limit (applicable limit from Worksheet S-2, line 56 and subscripts, column 2 times the corresponding trips from Worksheet S-3, line 27 and subscripts, column 4)) times 80 percent plus the fee schedule amounts (from Worksheet S-2, line 56 and subscripts, column 4) times 20 percent for the calendar year services beginning 4/1/2002. Subsequent dates and blends (cost percentage/fee percentage) are: Calendar year 2003 is 60/40, 2004 is 40/60, 2005 is 20/80, and 2006 and after is 100 percent fee schedule amounts. Once ambulance payment has transitioned to 100 percent of the fee amount (services rendered on or after 1/1/2006), line 56 will no longer include fee schedule payments.

Generally, CAHs follow the instructions for ambulance services subject to the limit (10/1/97b) and/or the blend (4/1/02s). However, CAHs eligible for cost reimbursement for ambulance (Worksheet S-2, line 30.03, column 1 = "Yes") multiply column 1 times column 5 and enter the result. (12/21/00s) *CAHs eligible for cost reimbursement for ambulance services (billed as exempt from the ambulance fee schedule) effective for cost reporting periods beginning on or after October 1, 2009, such ambulance services on line 65 are transferred from your records or PS&R report type 85C. Multiply column 1 times column 5 and enter the result.*

Column 10--Enter in this column the hospital inpatient Part B charges for services rendered prior to August 1, 2000 (10/1/90s).

Column 11--Enter in this column the hospital inpatient Part B costs computed by multiplying the charges in column 10 times the cost to charge ratio reported in column 1.02 (10/1/90s).

Line Descriptions

Line 44--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services rendered on or after November 29, 1999 will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital

laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2004, but before July 1, 2008 (Medicare, Medicaid, and SCHIP Extension Act of 2007, section 107). For title V and XIX purposes, follow applicable State program instructions.

For CAHs effective for services rendered on or after July 1, 2009, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, section 148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 45--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §3610 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 103.

Line 55--Enter in columns 2 through 5 the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 55.30--Enter in columns 2 through 5 the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics. See section 3610 line 55.30

Line 56--Enter the program charges for drugs charged to patients. Include charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under OPSS such as hepatitis vaccines. Do not include vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance. These charges are reported on Worksheet D, Part VI.

Line 57--The only renal dialysis services entered on this line are for inpatients who are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 5. Enter the related costs in column 9.

Line 58--Enter in columns 2 and 2.01 the outpatient ASC facility charges for the hospital nondistinct part ambulatory surgery center. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient. Enter in column 5 all other Part B charges applicable to services performed in the nondistinct ASC.

Lines 60 through 63--Use these lines for outpatient service cost centers.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC 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.

Line 62--Enter in columns 2 through 5 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the nondistinct observation beds and released. These patients were not admitted as inpatients.

Line 64--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program

dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 65--Enter in column 5.02 the total ambulance charges for PPS hospital providers (column 5 for non PPS hospitals). (8/2000)

Line 66 and 67--For title XVIII, DME is paid on a fee schedule through the carrier and, therefore, is not paid through the cost report.

Line 101--Enter the sum of lines 37 through 68.

Line 102--Generally, nonphysician anesthetist services are not subject to the ASC payment methodology for outpatient ambulatory surgical procedures performed in hospitals and as such are not reported on this worksheet unless you meet the exception described in §3610. Do not complete this line if you do not qualify for the exception. If the services meet the criteria for continued cost reimbursement, exclude nonphysician anesthetist charges from ASC charges in columns 2 and 2.01, line 102 and add these charges to column 5, line 102. Do not reduce the charges reported in columns 2 and 2.01, lines 37 through 68 (nor do you increase the charges in column 5) for CRNA charges. The reduction and addition are done in total on line 102. However, if you have separate charges for nonphysician anesthetists reported in the ancillary service cost centers where the services were performed, and the apportionment between ASC and all other Part B is not necessary, enter those charges directly in column 5, line 102, for services rendered before August 1, 2000. These costs are pass through costs when eligible for the exception and are reported on Worksheet D, Part IV.

EXAMPLE: If nonphysician anesthetist charges are included in operating room and anesthesiology charges reported on Worksheet D, Part V, column 2, lines 37 and 40, respectively, eliminate the charges from columns 2 and 2.01 and report them in column 5. This is accomplished by developing a ratio of each affected cost center's nonphysician anesthetist cost allocated on Worksheet B, Part I, column 20, lines 37 and 40 to the total cost reported on Worksheet B, Part I, column 27, lines 37 and 40. Each ratio is then multiplied by the charges applicable to Worksheet D, Part V, columns 2 and 2.01, lines 37 and 40. The result represents the CRNA charges for operating room and anesthesiology. These charges are added together and reported on line 102 as a decrease in columns 2 and 2.01 and an increase to column 5. Attach a separate reconciliation to the cost report showing this computation.

Step Instructions

- 1 $\frac{\text{Worksheet B, Part I, column 20, line 37}}{\text{Worksheet B, Part I, column 27, line 37}} = \text{ratio (six decimal places)}$
- 2 $\frac{\text{Worksheet B, Part I, column 20, line 40}}{\text{Worksheet B, Part I, column 27, line 40}} = \text{ratio (six decimal places)}$
- 3 The ratio in step 1 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 37 equals the CRNA operating room charges.
- 4 The ratio in step 2 multiplied by the charges reported on Worksheet D, Part V, columns 2 and 2.01, line 40 equals the CRNA anesthesiology charges.
- 5 Add the amounts in steps 3 and 4. Enter the total on line 102 as a decrease in columns 2 and 2.01 and as an increase in column 5, line 102.

- 6 To determine the costs reported in columns 6 and 9, line 102, multiply the ratio on Worksheet C, Part II, column 8, as applicable for each cost center (lines 37 and 40), by the charges computed in steps 3 and 4. Add these two costs together, and report the total as a decrease to columns 6 and 6.01 and an increase to column 9.

Line 103--Enter in column 5 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 45. Do not complete this line for column 9.

Line 104--Enter in columns 5 and 9, and subscripts, the amount on line 101 plus or minus the amounts on lines 102 and 103 if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 to Worksheet E, Part B, line 6. Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than PPS), transfer the sum of the amounts in columns 5 and subscripts and column 10, line 104 plus the amount from Worksheet D-4, column 2, line 103 to the appropriate Worksheet E-3, Part III, column 1, line 11.

For titles V and XIX (under PPS), transfer the amount in column 5, line 104 to the appropriate Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 104 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges, and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Transfer References

<u>From Wkst. D, Part V</u>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
Columns 6 & 6.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 6
Columns 2 & 2.01, line 104	N/A		Wkst. E, Part C, col. 1& 1.01, line 7
Columns 7 & 7.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 6
Columns 3 & 3.01, line 104	N/A		Wkst. E, Part D, col. 1& 1.01, line 7
Columns 8 & 8.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 6
Columns 4 & 4.01, line 104	N/A		Wkst. E, Part E, col. 1 & 1.01, line 7
Columns 9 and subscripts & column 11, Line 104	N/A		Wkst. E, Part B, col. 1 (& subscripts), line 1 & 1.01

Transfer References

<u>From Wkst. D, Part V</u>	<u>Title XVIII, Part B Swing Bed</u>	<u>To</u>	<u>Titles V or XIX or Title XVIII, Part B</u>
Sum of columns 5, 5.01 (SNF only) and 5.02, line 104	N/A		Wkst. E, Part B, line 6 or Wkst. E-3, Part III, col. 1, line 11 for titles V or XIX
Sum of columns 9 and 9.01 (SNF only) through 12/31/98 line 104	Wkst E-2 col. 2, line 3		Wkst. E, Part B, line 1 or Wkst. E-3, Part III, col. 1, line 2 for titles V or XIX

3621.6 Part VI - Vaccine Cost Apportionment.--This worksheet provides for the apportionment of costs applicable to the administration and cost of the drug for the following vaccines: Pneumococcal, Influenza, and Osteoporosis. These charges include, if applicable, vaccine services provided by hospital based RHC/FQHC which cannot be reported on Worksheet M-3 and M-4 (1/98). For services rendered on and after August 1, 2000 for vaccines provided by a RHC/FQHC will be reported on Worksheets M-3 and M-4. Pneumococcal and Influenza vaccines rendered on or after January 1, 2003 have transitioned back to cost reimbursed.

For services rendered prior to 4/1/2001 vaccines are reimbursed under cost. For services rendered from 4/1/2001 through 12/31/2002 vaccines are reimbursed under OPPS and will be included in the OPPS PS&R. Therefore vaccine cost will be included in worksheet D, Part V, columns 5.01 or 5.03 amounts for 4/1/2001 through 12/31/2002 (reimbursed at 80% of cost subject to coinsurance and deductibles) and flow to the proper lines on Worksheet E, Part B. For vaccines reimbursed at 100% of cost not subject to coinsurance and deductibles (pneumococcal and influenza vaccines rendered on or after January 1, 2003) Worksheet D, Part VI, line 3, will be transferred to Worksheet E, Part B, line 1.

Line 1--Enter the cost to charge ratio from Worksheet C, Part I, column 9, line 56.

Line 2--Enter the program charges from the PS&R or from provider records. Effective for services rendered on or after April 1, 2001, subscript this line and report charges prior to April 1, 2001, on line 2 and on line 2.01 charges on or after April 1, 2001. For cost reporting periods beginning on or after April 1, 2001, no subscripting is required except for cost reporting periods which overlap January 1, 2003.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines and the charges for hepatitis B vaccines on worksheet D, Part V as hepatitis B vaccine charges are subject to deductibles and coinsurance.

Line 3--Multiply line 1 times line 2, for hospital services rendered prior to April 1, 2001, and enter the result on line 3. For services rendered on or after April 1, 2001, subscript this line and enter on line 3.01 the result of line 1 times line 2.01. For cost reporting periods beginning on or after April 1, 2001, no subscripting is required, except for cost reporting periods which overlap January 1, 2003. For hospitals for title XVIII, transfer the amount on line 3 to Worksheet E, Part B, line 1 for services rendered prior to April 1, 2001 and on or after January 1, 2003. The amount on line 3.01 is added to

the amount reported on Worksheet D, Part V, column 9.01, line 104 and transferred to Worksheet E, Part B, line 1.01 for services rendered on or after April 1, 2001 and before January 1, 2003. For SNFs transfer to Worksheet E, Part B, line 1, the sum of lines 3 and 3.01, but for reporting periods beginning on or after April 1, 2001, transfer the amount from line 3 only. For swing bed SNFs transfer the amount from line 3 to Worksheet E-2, column 2, line 3 and for NFs to Worksheet E-3, Part III, column 1, line 2, for titles V and XIX.

For CAHs effective for services rendered on or after November 29, 1999, enter on line 2 the program charges for pneumococcal, influenza, and osteoporosis vaccines. Transfer the amount on line 3 to Worksheet E, Part B, line 1.

3622. WORKSHEET D-1 - COMPUTATION OF INPATIENT OPERATING COST

This worksheet provides for the computation of hospital inpatient operating cost in accordance with 42 CFR 413.53 (determination of cost of services to beneficiaries), 42 CFR 413.40 (ceiling on rate of hospital cost increases), and 42 CFR 412.1 through 412.125 (prospective payment). All providers must complete this worksheet.

Complete a separate copy of this worksheet for the hospital, each subprovider, hospital-based SNF, and hospital-based other nursing facility. Also, complete a separate copy of this worksheet for each health care program under which inpatient operating costs are computed. When this worksheet is completed for a component, show both the hospital and component numbers.

At the top of each page, indicate by checking the appropriate line the health care program, provider component, and the payment system for which the page is prepared.

Worksheet D-1 consists of the following four parts:

- Part I - All Provider Components
- Part II - Hospital and Subproviders Only
- Part III - Skilled Nursing Facility and Other Nursing Facility Only
- Part IV - Computation of Observation Bed Cost

NOTE: If you have made a swing bed election for your certified SNF, treat the SNF costs and patient days as though they were hospital swing bed-SNF type costs and patient days on Parts I and II of this worksheet. Do not complete Part III for the SNF. (See CMS Pub. 15-I, §2230.9B.)

Definitions

The following definitions apply to days used on this worksheet.

Inpatient Day--The number of days of care charged to a beneficiary for inpatient hospital services is always in documented units of full days. A day begins at midnight and ends 24 hours later. Use the midnight to midnight method in reporting the days of care for beneficiaries even if the hospital uses a different definition for statistical or other purposes.

A part of a day, including the day of admission, counts as a full day. However, do not count the day of discharge or death, or a day on which a patient begins a leave of absence, as a day. If both admission and discharge or death occur on the same day, consider the day a day of admission and count it as one inpatient day.

Include a maternity patient in the labor/delivery room ancillary area at midnight in the census of the inpatient routine (general or intensive) care area only if the patient has occupied an inpatient routine bed at some time since admission. Count no days of inpatient routine care for a maternity inpatient who is discharged (or dies) without ever occupying an inpatient routine bed. However, once a maternity patient has occupied an inpatient routine bed, at each subsequent census include the patient in the census of the inpatient routine care area to which she is assigned, even if the patient is located in an ancillary area (labor/delivery room or another ancillary area) at midnight. In some cases, a maternity patient may occupy an inpatient bed only on the day of discharge if the day of discharge differs from the day of admission. For purposes of apportioning the cost of inpatient routine care, count this single day of routine care as the day of admission (to routine care) and discharge. This day is considered as one day of inpatient routine care. (See CMS Pub. 15-I, §2205.2.)

When an inpatient is occupying any other ancillary area (e.g., surgery or radiology) at the census taking hour prior to occupying an inpatient bed, do not record the patient's occupancy in the ancillary area as an inpatient day in the ancillary area. However, include the patient in the inpatient census of the routine care area.

When the patient occupies a bed in more than one patient care area in one day, count the inpatient day only in the patient care area in which the patient was located at the census taking hour.

Newborn Inpatient Day--Newborn inpatient days are the days that an infant occupies a newborn bed in the nursery. Include an infant remaining in the hospital after the mother is discharged who does not occupy a newborn bed in the nursery, an infant delivered outside the hospital and later admitted to the hospital but not occupying a newborn bed in the nursery, or an infant admitted or transferred out of the nursery for an illness in inpatient days. Also, include an infant born in and remaining in the hospital and occupying a newborn bed in the nursery after the mother is discharged in newborn inpatient days.

Private Room Inpatient Day--Private room inpatient days are the days that an inpatient occupies a private room. If you have only private rooms, report your days statistic as general inpatient days. Inpatient private room days are used for computing any private room differential adjustment on Worksheet D-1, Part I if you have a mixture of different type rooms to accommodate patients. Do not count swing bed-SNF or swing bed-NF type services rendered in a private room as private room days.

Inpatient Swing Bed Days--Inpatient swing bed days are the days applicable to swing bed-SNF or swing bed-NF type services. See 413.53(a)(2)

Intensive Care Type Inpatient Days--Intensive care type inpatient days are those days applicable to services rendered in intensive care type inpatient hospital units. These units must meet the requirements specified in CMS Pub. 15-I, §2202.7.II.A.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type inpatient hospital days for purposes of computing the intensive care type inpatient hospital unit per diem. However, count the program days as general routine days in computing program reimbursement. (See CMS Pub. 15-I, §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital or subprovider which are not organized as a distinct, separately staffed observation area and which are used to house patients for observation. These beds need not be used

full time for observation patients. These beds are not to be confused with a subintensive care unit (i.e., definitive observation unit, a stepdown from intensive care reported as an inpatient cost center following surgical intensive care (line 29)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 62.01 on Worksheet A.

3622.1 Part I - All Provider Components.--This part provides for the computation of the total general inpatient routine service cost net of swing bed cost and private room cost differential for each separate provider component. When this worksheet is completed for a component, show both the hospital and component numbers.

Line Descriptions

Lines 1 through 16--Inpatient days reported, unless specifically stated, exclude days applicable to newborn and intensive care type patient stays. Report separately the required statistics for the hospital, each subprovider, hospital-based SNF, hospital-based other nursing facility and ICF/MR. Obtain the information from your records and/or Worksheet S-3, Part I, columns and lines as indicated.

Line 1--Enter the total general routine inpatient days, including private room days, swing bed days, observation bed days, and hospice days, as applicable. Do not include routine care days rendered in an intensive care type inpatient hospital unit. Enter the total days from Worksheet S-3, Part I, column 6 for the component and lines as indicated: hospitals from lines 5 and 26; subproviders from lines 14 and 26.01, if applicable; SNFs from line 15; and NFs from line 16. If you answered yes to line 38.03 of Worksheet S-2, the NF days come from line 15 for the SNF level of care and line 16 for the NF level of care, and you will need to prepare a separate Worksheet D-1 for each level of care for title XIX.

NOTE: If you are a rural hospital with a certified SNF, have less than 50 beds in the aggregate for both components (excluding intensive care type and newborn beds), and have made an election to be reimbursed as though you were a swing bed hospital, treat the SNF total and SNF program patient days as though they were hospital swing bed-SNF days. Report them on lines 1, 5, 6, 10, and 11, as appropriate. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.9.B.)

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Hospitals and enter the sum of the days entered on Worksheet S-3, Part I, column 6, lines 1 and 26. Subproviders, SNFs, and NFs enter the days from line 1 of this worksheet.

Line 3--Enter the total private room days excluding swing bed private room days.

Line 4--Enter the number of days reported on line 2 less the number of days reported on line 3.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-I, §2207.3.)

Line 5--Enter the total swing bed-SNF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing bed-SNF type inpatient days.

Line 6--Enter the total swing bed-SNF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. The sum of lines 5 and 6 equals Worksheet S-3 Part I, line 3, column 6.

Line 7--Enter the total swing bed-NF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all swing bed-NF type inpatient days. This line includes title V, title XIX, and all other payers.

Line 8--Enter the total swing bed-NF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero. This line includes title V, title XIX, and all other payers. The sum of lines 7 and 8 equals Worksheet S-3, Part I, line 4, column 6.

NOTE: Obtain the amounts entered on lines 5 and 7 from your records.

Line 9--Enter the total program general routine inpatient days as follows:

<u>Type of Provider</u>	<u>From</u>
Hospital	Wkst. S-3, Part I, cols. 3, 4, or 5, line 1
Subprovider	Wkst. S-3, Part I, cols. 3, 4, or 5, line 14
SNF	Wkst. S-3, Part I, cols. 3, 4, or 5, line 15
NF	Wkst. S-3, Part I, cols. 3, 4, or 5, for SNF only level of care; line 15. If line 38.03 of Wkst S-2 is a "Y", two D-1s must be completed for title XIX using line 15 for SNF level of care and line 16 for the NF level of care; or line 16 only for NF level of care.

Include private room days and exclude swing bed and newborn days for each provider component. Add any program days for general care patients of the component who temporarily occupied beds in an intensive care or other special care unit. (See CMS Pub. 15-I, §2217.)

Line 10--Enter the title XVIII swing bed-SNF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing bed-SNF type inpatient days. Combine titles V and XIX for all SNF lines if your State recognizes only SNF level of care.

Line 11--Enter the title XVIII swing bed-SNF type inpatient days, including private room days, after December 31 of your cost reporting period. If you are on a calendar year end, enter zero.

Line 12--Enter the total titles V or XIX swing bed-NF type inpatient days, including private room days, through December 31 of your cost reporting period. If you are on a calendar year end, report all program swing bed-NF type inpatient days.

Line 13--Enter the total titles V or XIX swing bed-NF type inpatient days, including private room days, after December 31 of your reporting period. If you are on a calendar year end, enter zero.

NOTE: If you are participating in both titles XVIII and XIX, complete, at a minimum, a separate Worksheet D-1, Part I, for title XIX, lines 9, 12, and 13. If these data are not supplied, the cost report is considered incomplete and is rejected.

Line 14--Enter the total medically necessary private room days applicable to the program, excluding swing bed days, for each provider component.

Line 15--Enter, for titles V or XIX only, the total nursery inpatient days from Worksheet S-3, Part I, column 6, line 11.

Line 16--Enter, for titles V or XIX only, the total nursery inpatient days applicable to the program from Worksheet S-3, Part I, columns 3 and 5, respectively, line 11.

Lines 17 through 27--These lines provide for the carve out of reasonable cost of extended care services furnished by a swing bed hospital. Under the carve out method, the total costs attributable to SNF type and NF type routine services furnished to all classes of patients are subtracted from total

general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your intermediary.

Line 17--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 5 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

Line 18--Enter the Medicare swing-bed SNF rate applicable to the calendar year in which inpatient days on line 6 occurred. If the swing-bed SNF rate for the prior calendar year is higher, enter that rate instead. (See CMS Pub. 15-I, §2230ff.) Critical access hospitals do not complete this line (12/00).

Line 19--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State. This rate is approximated by taking the average rate from the prior calendar year (i.e. the calendar year preceding the year relating to inpatient days reported on line 7), updated to approximate the current year rate. Obtain the proper rate from your FI/MAC.

Line 20--Enter the average Statewide rate per patient day paid under the State Medicaid plan for routine services furnished by nursing facilities (other than NFs for the mentally retarded) in that State. This rate is approximated by taking the average rate from the prior calendar year (i.e. the calendar year preceding the year relating to inpatient days reported on line 8), updated to approximate the current year rate. Obtain the proper rate from your FI/MAC.

Line 21--Enter the total general inpatient routine service costs for the applicable provider component.

For titles V, XVIII, and XIX, enter the amounts from Worksheet C, Part I, line 25 for adults and pediatrics or line 31 for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1
TEFRA	Inpatient - Column 3, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "N", respectively.
PPS	Inpatient - Column 5, for IRFs & LTCHs if Wksht. S-2, line 58 (IRF) or 59 (LTCH), respectively, columns 1 and 2 are "Y" & "Y", respectively.

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 34 (SNF) (7/1/98b). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 27, line 35 (NF) or 35.01 ICF/MR.

Line 22--Enter the product of the days on line 5 multiplied by the amount on line 17.

Line 23--Enter the product of the days on line 6 multiplied by the amount on line 18.

Line 24--Enter the product of the days on line 7 multiplied by the amount on line 19.

Line 25--Enter the product of the days on line 8 multiplied by the amount on line 20.

Line 26--Enter the sum of the amounts on lines 22 through 25. This amount represents the total reasonable cost for swing bed-SNF type and NF type inpatient services.

For critical access hospitals, for cost reporting periods beginning on or after December 21, 2000, subtract the sum of lines 24 and 25 from the amount reported on line 21. Divide that result by the patient days equal to lines 2, 5, and 6 above to arrive at a per diem (Retain this amount for the calculation required on lines 38, 60 and 61). Multiply the per diem by the total days reported on lines 5 and 6. Add that result to the amounts reported on lines 24 and 25.

Line 27--Subtract the amount on line 26 from the amount on line 21. This amount represents the general inpatient routine service cost net of swing bed-SNF type and NF type inpatient costs.

Lines 28 through 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 3 equals line 2 above you are not to complete these lines.

Line 28--Enter the total charges for general inpatient routine services, excluding charges for swing bed-SNF type and NF type inpatient services (from your records).

Line 29--Enter the total charges for private room accommodations, excluding charges for private room accommodations for swing bed-SNF type and NF type inpatient services (from your records).

Line 30--Enter the total charges for semi-private room and ward accommodations, excluding semi-private room accommodation charges for swing bed-SNF type and NF type services (from your records).

Line 31--Enter the general inpatient routine cost to charge ratio (rounded to six decimal places) by dividing the total inpatient general routine service costs (line 27) by the total inpatient general routine service charges (line 28).

Line 32--Enter the average per diem charge (rounded to two decimal places) for private room accommodations by dividing the amount on line 29 by the days on line 3.

Line 33--Enter the average per diem charge (rounded to two decimal places) for semi-private accommodations by dividing the amount on line 30 by the days on line 4.

Line 34--Subtract the average per diem charge for all semi-private accommodations (line 33) from the average per diem charge for all private room accommodations (line 32) to determine the average per diem private room charge differential. If a negative amount results from this computation, enter zero on line 34.

Line 35--Multiply the average per diem private room charge differential (line 34) by the inpatient general routine cost to charge ratio (line 31) to determine the average per diem private room cost differential (rounded to two decimal places).

Line 36--Multiply the average per diem private room cost differential (line 35) by the private room accommodation days (excluding private room accommodation days applicable to swing bed-SNF type and NF type services) (line 3) to determine the total private room accommodation cost differential adjustment.

Line 37--Subtract the private room cost differential adjustment (line 36) from the general inpatient routine service cost net of swing bed-SNF type and NF type costs (line 27) to determine the adjusted general inpatient routine service cost net of swing bed-SNF type service costs, NF type service costs, and the private room accommodation cost differential adjustment. If line 3 equals line 2, enter the amount from line 27 above.

3622.2 Part II - Hospital and Subproviders Only--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the calculation of program excludable cost for all hospitals and subproviders. For hospitals reimbursed under TEFRA, it provides for the application of a ceiling on the rate of cost increase for the hospital and subproviders. When the worksheet is completed for a component, show both the hospital and component numbers.

NOTE: This is not completed for RPCH providers. (See Worksheet S-2, line 31ff.) RPCH providers complete Worksheet C, Part IV, in lieu of this part. For cost reporting periods beginning after October 1, 1997 CAHs will complete this worksheet.

Line Descriptions

Line 38--For non-PPS providers (includes IRFs and LTCHs during the TEFRA/PPS blend), divide the adjusted general inpatient routine service cost (line 37) by the total general inpatient routine service days including private room (excluding swing bed and newborn) days (line 2) to determine the general inpatient routine service average cost per diem (rounded to two decimal places). For PPS providers (includes IRFs and LTCHs under 100 percent PPS), divide the sum of lines 36 and 37 by the inpatient days reported on line 2. For CAHs the per diem, unless there is an adjustment for private room differential, should be equal to the per diem calculated in the formula on line 26. If this is a CAH and there is a private room differential, process as a non PPS provider,

Line 39--Multiply the total program inpatient days including private room (excluding swing bed and newborn) days (line 9) by the adjusted general inpatient routine service average cost per diem (line 38) to determine the general inpatient service cost applicable to the program.

Line 40--Multiply the medically necessary private room (excluding swing bed) days applicable to the program (line 14) by the average per diem private room cost differential (line 35) to determine the reimbursable medically necessary private room cost applicable to the program. PPS providers including IRF, IPF and LTCH, reimbursed at 100 percent Federal rate enter zero.

Line 41--Add lines 39 and 40 to determine the total general inpatient routine service cost applicable to the program.

Line 42--This line is for titles V and XIX only and provides for the apportionment of your inpatient routine service cost of the nursery, as appropriate.

Column 1--Enter the total inpatient cost applicable to the nursery from Worksheet C, Part I, line 33.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter the total inpatient days applicable to the nursery from line 15.

Column 3--Divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter the program nursery days from line 16.

Column 5--Multiply the average per diem cost in column 3 by the program nursery days in column 4.

Lines 43 through 47--These lines provide for the apportionment of the hospital inpatient routine service cost of intensive care type inpatient hospital units (excluding nursery) to the program.

Column 1--Enter on the appropriate line the total inpatient routine cost applicable to each of the indicated intensive care type inpatient hospital units from Worksheet C, Part I, lines 26 through 30, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient	Column 5

Column 2--Enter on the appropriate line the total inpatient days applicable to each of the indicated intensive care type inpatient units. Transfer these inpatient days from Worksheet S-3, Part I, column 6, lines 6 through 10, as appropriate.

Column 3--For each line, divide the total inpatient cost in column 1 by the total inpatient days in column 2 (rounded to two decimal places).

Column 4--Enter on the appropriate line the program days applicable to each of the indicated intensive care type inpatient hospital units. Transfer these inpatient days from Worksheet S-3, Part I, columns 3, 4, or 5, as appropriate, lines 6 through 10.

NOTE: When you place overflow general care patients temporarily in an intensive care type inpatient hospital unit because all beds available for general care patients are occupied, count the days as intensive care type unit days for the purpose of computing the intensive care type unit per diem. The days are included in column 2. However, count the program days as general routine days in computing program reimbursement. Enter the program days on line 9 and not in column 4, lines 43 through 47, as applicable. (See CMS Pub. 15-I, §2217.)

Column 5--Multiply the average cost per diem in column 3 by the program days in column 4.

Line 48--Enter the total program inpatient ancillary service cost from the appropriate Worksheet D-4, column 3, line 101.

Line 49--Enter the sum of the amounts on lines 41 through 48. When this worksheet is completed for components, neither subject to prospective payment, nor subject to the target rate of increase ceiling (i.e., "Other" box is checked), transfer this amount to Worksheet E-3, Part II, line 1 or Part III, column 1, line 1, as appropriate. Do not complete lines 50-59. For all inclusive rate providers (Method E) apply the percentage to the sum of the aforementioned lines based on the provider type designated on Worksheet S-2, line 19 (see PRM 15-I, section 2208).

Lines 50-53--These lines compute total program inpatient operating cost less program capital-related, nonphysician anesthetists, and approved medical education costs. Complete these lines for all provider components.

Line 50--Enter on the appropriate worksheet the total pass through costs including capital-related costs applicable to program inpatient routine services. Transfer capital-related inpatient routine cost from Worksheet D, Part I, columns 10 and 12, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 8, sum of lines 25 through 30 and line 33 for the hospital, and line 31 for the subprovider.

Line 51--Enter the total pass through costs including capital-related costs applicable to program inpatient ancillary services. Transfer capital-related inpatient ancillary costs from Worksheet D, Part II, sum of columns 6 and 8, line 101. Add that amount to the other pass through costs from Worksheet D, Part IV, column 7, line 101.

Line 52--Enter the sum of lines 50 and 51.

Line 53--Enter total program inpatient operating cost (line 49) less program capital-related, nonphysician anesthetists (if appropriate), and approved medical education costs (line 52).

Lines 54 through 59--Except for those hospitals specified below, all hospitals (and distinct part hospital units) excluded from prospective payment are reimbursed under cost reimbursement principles and are subject to the ceiling on the rate of hospital cost increases (TEFRA). (See 42 CFR 413.40.) The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- o Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.205 through 403.258);

- o Hospitals reimbursed in accordance with demonstration projects authorized under §402(a) of the Social Security Amendments of 1967 or §222(a) of the Social Security Amendments of 1972; and
- o Nonparticipating hospitals furnishing emergency services to Medicare beneficiaries.

For your components subject to the prospective payment system or not otherwise subject to the rate of increase ceiling as specified above, make no entries on lines 54 through 59.

NOTE: A new non-PPS hospital or subprovider (Lines 34 and/or 35 of Worksheet S-2 with a “Y” response) is cost reimbursed for all cost reporting periods through the end of its first 12 month cost reporting period. The 12 month cost reporting period also becomes the TEFRA base period unless an exemption under 42 CFR 413.40 (f) is granted. If such an exemption is granted, cost reimbursement continues through the end of the exemption period. The last 12 month period of the exemption is the TEFRA base period. For cost reporting periods beginning on or after October 1, 1997, new providers will be paid the lower of their inpatient operating costs per case or 110 percent of the national median of the target amounts for similar provider types.

Line 54--Enter the number of program discharges including deaths (excluding newborn and DOAs) for the component from Worksheet S-3, Part I, columns 12 through 14 (as appropriate), lines 12 and 14 (as appropriate). A patient discharge, including death, is a formal release of a patient.

Line 55--Enter the target amount per discharge as obtained from your intermediary. The target amount establishes a limitation on allowable rates of increase for hospital inpatient operating cost. The rate of increase ceiling limits the amount by which your inpatient operating cost may increase from one cost reporting period to the next. (See 42 CFR 413.40.)

Line 56--Multiply the number of discharges on line 54 by the target amount per discharge on line 55 to determine the rate of increase ceiling.

Line 57--Subtract line 53 from line 56 to determine the difference between adjusted inpatient operating cost and the target amount.

Line 58 through 58.04--This line provides incentive payments when your cost per discharge for the cost reporting period subject to the ceiling is less than the applicable target amount per discharge. In addition, for cost reporting periods beginning on or after October 1, 1997, bonus payments are provided for hospitals who have received PPS exempt payments for three or more previous cost reporting periods and whose operating costs are less than the target amount, expected costs (lesser of actual costs or the target amount for the previous year), or trended costs (lesser of actual operating costs or the target amount in 1996; or for hospitals where its third full cost reporting period was after 1996 the inpatient operating cost per discharge), updated and compounded by the market basket. It also provides for an adjustment when the cost per discharge exceeds the applicable target amount per discharge. If line 57 is zero, enter zero on lines 58 through 58.04. New providers skip lines 58 through 58.04 and go to line 59.

Line 58--If line 57 is a positive amount (actual inpatient operating cost is less than the target amount), enter on line 58 the lesser of 50 percent of line 57 or 5 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, the respective percentages are 15 percent and 2 percent. However, the respective percentages are 15 percent and 3 percent for psychiatric hospital/subprovider for cost reporting periods beginning on or after October 1, 2000 and before October 1, 2001, (see BIPA §306 and 42CFR 413.40(d)(2)). If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) for cost reporting periods beginning prior to October 1, 1997, enter on line 58, the lesser of 50 percent of the absolute value of line 57 or 10 percent of line 56. For cost reporting periods beginning on or after October 1, 1997, do not complete line 58 (leave blank) and complete line 58.04 for calculation of any adjustments to the operating costs when line 57 is negative.

Line 58.01--Starting with the first full cost reporting period and counting forward, enter from the third full cost reporting period the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated and compounded by the market basket for each year through the current reporting year. If the third full cost reporting period ended during or before the Federal fiscal year 1996 use the amounts from fiscal year 1996. For hospitals where its third full cost reporting period ended in the Federal fiscal year 1997 or subsequent fiscal period enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 58.02--Enter from the prior year cost report, the lesser of the hospital's inpatient operating cost per discharge (line 53/line 54) or line 55, updated by the market basket.

Line 58.03--For cost reporting periods beginning on or after October 1, 1997, if (line 53/line 54) is less than the lower of lines 55, 58.01 or 58.02, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 58.02), or 1 percent of the target amount (line 56); otherwise enter zero. *See 42 CFR 413.40(d)(4)(i).*

For long-term care hospitals and psychiatric hospitals or psychiatric subproviders the 1 percent limitation is increased to 1.5 percent for cost reporting periods beginning on and after October 1, 2000 and before October 1, 2001 and to 2 percent for cost reporting periods beginning on or after October 1, 2001 and before October 1, 2002. For cost reporting periods beginning on or after 10/1/2002, the instructions in the above paragraph are again applicable.

Line 58.04--If line 57 is a negative amount (actual inpatient operating cost is greater than the target amount) and line 53 is greater than 110 percent of line 56, enter on this line the lesser of (1) or (2): (1) 50 percent of the result of (line 53 minus 110 percent of line 56) or (2) 10 percent of line 56; otherwise enter zero. *See 42 CFR 413.40(d)(3).*

Line 59--For cost reporting periods beginning prior to October 1, 1997, enter the sum of lines 52 and 58 plus the lesser of line 53 or line 56. For cost reporting periods beginning on or after October 1, 1997, if line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 58.03 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 58.04. If line 57 is zero, enter the sum of lines 52 and 56. New providers enter the lesser of lines 53 or 56 plus line 52. TEFRA providers (42 CFR §413.40(j)), except cancer and children's hospitals, for services rendered on and after October 1, 1997 and on or before September 30, 2002, are required to reduce capital to 85 percent of reported costs. To recalculate line 52, for cost reporting periods that overlap the October 1, 1997 effective date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and after October 1, 1997, to total days for the period. Multiply that result by 85 percent and add to that 100 percent of the ratio of days prior to October 1, 1997, to total days applied to the capital pass through amount. For cost reporting periods beginning on or after October 1, 1997, multiply the capital amount reported on lines 50 and 51 by 85 percent. Add the result of the 85 percent of capital to the non capital pass through costs included on lines 50 and 51 (10/1/97s). To recalculate line 52, for cost reporting periods that overlap the September 30, 2002 expiration date, multiply the capital pass through costs included on lines 50 and 51 of Worksheet D-1, which are obtained from Worksheet D, Parts I and II, by the ratio of days on and before September 30, 2002, to total days for the period applied to the capital pass through amount. Multiply that result by 85 percent and add to that 100 percent of the ratio of days after September 30, 2002, to total days for the period. For cost reporting periods beginning on or after October 1, 2002, multiply the capital amount reported on lines 50 and 51 by 100 percent. Add the result of the 100 percent of capital to the non capital pass through costs included on lines 50 and 51 as the capital reduction is no longer applicable (9/30/02s).

Lines 59.01 through 59.08--Lines 59.01 through 59.08 will be completed for long-term care providers with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 59.01--Enter the allowable inpatient cost per discharge, computed as line 59 divided by line 54.

Line 59.02--Enter the number of program discharges occurring from the beginning of the cost reporting period through June 30. For full year cost reporting periods ending June 30, this amount will agree with the discharges entered on line 54.

Line 59.03--Enter the number of program discharges occurring from July 1 through the end of the cost reporting period.

NOTE: Subscripted line 59.04 and 59.07 will be required for cost reporting periods greater than 12 months that overlap two July 1 dates.

Line 59.05 through 59.07--Compute the reduced inpatient cost per discharge for each period by applying the appropriate budget neutrality factor to the allowable inpatient cost per discharge reported on line 59.01. Budget neutrality factors have been identified in the Federal Register dated August 30, 2002, page 56034; June 6, 2003, page 34153; May 7, 2004, page 25703; *May 6, 2005, page 24202; May 12, 2006, page 27841; and May 11, 2007, page 26900* and are reflected as follows:

- 93.40 percent for discharges occurring from 10/1/2002 through 6/30/2003.
- 94.00 percent for discharges occurring from 7/1/2003 through 6/30/2004.
- 99.50 percent for discharges occurring from 7/1/2004 through 6/30/2005.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2005 through 6/30/2006.
- 1.000 (a 0.0 percent reduction) for discharges occurring from 7/1/2006 through 6/30/2007.
- *The budget neutrality factor is not computed for discharges occurring on or after 7/1/2007.*

Line 59.08--Enter the sum lines 59.02 times 59.05, 59.03 times 59.06, and 59.04 times 59.07 (if applicable). Transfer this amount to Worksheet E-3, Part I, line 1 for long-term care hospital providers with cost reporting periods beginning on or after October 1, 2002, and before October 1, 2006, that have not elected to be reimbursed at 100 percent of the Federal rate.

Line 60--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 line 10 by the rate used on line 17. For CAH multiply line 10 times the per diem calculated on line 38 (12/21/00b).

Line 61--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 line 11 by the rate used on line 18. For CAH multiply line 11 times the per diem calculated on line 38 (12/21/00b).

Line 62--Enter the sum of lines 60 and 61. Transfer this amount to the appropriate Worksheet E-2, column 1, line 1 for cost reporting periods beginning prior to July 1, 2002. However, CAHs continue to transfer this amount to worksheet E-2.

Line 63--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost through December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 12 by the rate used on line 19.

Line 64--Enter the amount of titles V or XIX swing bed-NF type inpatient routine cost for the period after December 31 of the cost reporting period. Determine this amount by multiplying the program swing bed-NF type inpatient days on line 13 by the rate used on line 20.

Line 65--Enter the sum of lines 63 and 64. Transfer this amount to the appropriate Worksheet E-2, column 1, line 2. If your state recognizes only one level of care obtain the amount from line 62.

3622.3 Part III - Skilled Nursing Facility, Other Nursing Facility, and Intermediate Care Facility/Mental Retardation Only.--This part provides for the apportionment of inpatient operating costs to titles V, XVIII, and XIX and the application of a limitation on reimbursable cost for these provider components. If the hospital-based SNF elects reimbursement under PPS for cost reporting periods beginning prior to July 1, 1998, complete lines 66 through 70 for data purposes only. For cost reporting periods beginning on or after July 1, 1998, complete lines 66 through 82 for data purposes only. When this worksheet is completed for a component, show both the hospital and component numbers. Any reference to the nursing facility will also apply to the intermediate care facility/mental retardation unit.

NOTE: If you have made a swing bed election for your certified SNF and hospital complex, do not complete this part for the SNF (Worksheet S-2, line 29 response is "Y"). Treat all the days and costs as swing bed days and costs and include them with the hospital. (See CMS Pub. 15-I, §2230.9B.)

Line Descriptions

Line 66--Enter the SNF or other nursing facility routine service cost from Part I, line 37.

Line 67--Determine the adjusted general inpatient routine service cost per diem by dividing the amount on line 66 by inpatient days, including private room days, shown on Part I, line 2.

Line 68--Determine the routine service cost by multiplying the program inpatient days, including the private room days in Part I, line 9, by the per diem amount on line 67.

Line 69--Determine the medically necessary private room cost applicable to the program by multiplying the days shown in Part I, line 14 by the per diem in Part I, line 35.

Line 70--Add lines 68 and 69 to determine the total program general inpatient routine service cost.

Line 71--Enter the capital-related cost allocated to the general inpatient routine service cost center. For title XVIII, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 34 (SNF). For titles V and XIX, transfer this amount from Worksheet B, sum of Parts II and III, column 27, line 35 (NF).

Line 72--Determine the per diem capital-related cost by dividing the amount on line 71 by the days in Part I, line 2.

Line 73--Determine the program capital-related cost by multiplying line 72 by the days in Part I, line 9.

Line 74--Determine the inpatient routine service cost by subtracting line 73 from line 70.

Line 75--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 76--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 75 from line 74.

NOTE: If you are a new provider not subject to the inpatient routine service cost per diem limitation, do not complete lines 77 and 78. (See 42 CFR 413.30(e)(2).)

Line 77--Enter the inpatient routine service cost per diem limitation. This amount is provided by your intermediary. This information is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 78--Enter the inpatient routine service cost limitation. Obtain this amount by multiplying the number of inpatient days shown on Part I, line 9 by the cost per diem limitation on line 77. This computation is no longer required for cost reporting periods beginning on or after July 1, 1998.

Line 79--Enter the amount of reimbursable inpatient routine service cost determined by adding line 73 to the lesser of line 76 or line 78. If you are a new provider not subject to the inpatient routine service cost limit, enter the sum of lines 73 and 76. For title XVIII, for cost reporting periods beginning on or after July 1, 1998, enter the amount from line 70.

Line 80-- Enter the program ancillary service amount from Worksheet D-4, column 3, line 101.

Line 81--Enter (only when Worksheet D-1 is used for a hospital-based SNF and NF) the applicable program's share of the reasonable compensation paid to physicians for services on utilization review committees to an SNF and/or NF. Include the amount eliminated from total costs on Worksheet A-8. If the utilization review costs are for more than one program, the sum of all the Worksheet D-1 amounts reported on this line must equal the amount adjusted on Worksheet A-8.

Line 82--Enter the total program inpatient operating cost by adding the amounts on lines 79 through 81. Transfer this amount to the appropriate Worksheet E-3, Part II, line 1 except for SNFs participating in the NHCQM demonstration and SNFs with cost reporting periods beginning on or after July 1, 1998. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part III, column 1, line 1 for titles V and XIX.

3622.4 Part IV - Computation of Observation Bed Pass Through Cost--This part provides for the computation of the total observation bed costs and the portion of costs subject to reimbursement as a pass through cost for observation beds that are in the general acute care routine area of the hospital and/or subprovider. A separate computation must be made if a subprovider is claiming observation bed costs. For title XIX, insert the amount calculated for title XVIII for the hospital and subprovider, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 83--Enter the total observation bed days from your records. Total observation days for the hospital and subprovider (if applicable) should equal the days computed on Worksheet S-3, Part I, column 6, line 26.

Line 84--Enter the result of general inpatient routine cost on line 27 divided by line 2.

Line 85--Multiply the number of days on line 83 by the cost on line 84 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 62. When transferring the amount to Worksheet C, be sure to combine with the subprovider if applicable.

Lines 86 through 89--These lines compute the observation bed costs used to apportion the routine pass through costs and capital-related costs associated with observation beds for PPS and TEFRA providers.

Column 1--For line 86, transfer the amount from Worksheet D, Part I, column 1, line 25 for the hospital and line 31 for the subprovider, if applicable. For line 87, transfer the amount from Worksheet D, Part I, column 4, line 25 or line 31. For lines 88 and 89, enter on each line the cost from Worksheet D, Part III, columns 1 and 2 and subscripts respectively, line 25 or line 31. Subscript line 89 to agree with Worksheet D, Part III, columns 2, 2.01 and 2.02 (01/00).

Column 2--Enter on each line the general inpatient routine cost from line 27. Enter the same amount on each line.

Column 3--Divide column 1 by column 2 for each line, and enter the result. If there are no costs in column 1, enter 0 in column 3.

Column 4--Enter the total observation cost from line 85 on each line. Enter the same amount on each line.

Column 5--Multiply the ratio in column 3 by the amount in column 4. Use this cost to apportion routine pass through costs associated with observation beds on Worksheet D, Parts II and IV.

Transfer the amount in column 5:

<u>From</u>	<u>To</u>	<u>To</u>
<u>Wkst. D-1, Part IV</u>	<u>Wkst. D, Part II</u>	<u>Wkst D, Part IV</u>
Col. 5, line 86	Col. 1, line 62	
Col. 5, line 87	Col. 2, line 62	
Col. 5, line 88		Col. 1, line 62
Col. 5, line 89 and subscripts		Col. 2, line 62 and subscripts

If observation bed services are also furnished by a subprovider, transfer to the hospital's and subprovider's Worksheet D, Parts II and IV the sum of the hospital's and subprovider's amounts from Worksheet D-1, Part IV

3623. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

3623.1 Part I - Not in Approved Teaching Program.--Use this part only if you have interns and residents who are not in an approved teaching program. (See CMS Pub. 15-I, chapter 4.) If you have more than one hospital-based outpatient rehabilitation provider, subscript line 16 to accommodate reporting data for each.

Column 1--Enter the percentage of time that interns and residents are assigned to each of the indicated patient care areas on lines 1 through 18 and 20 through 23 (from your records).

NOTE: If you are a rural hospital with a certified SNF, have less than 50 beds in the aggregate for both components excluding intensive care type and newborn beds, and have made an election to be reimbursed as though you are a swing bed hospital, the SNF patient days are treated as though they are hospital swing bed-SNF type patient days and are combined with the hospital adults and pediatrics cost center on line 2 for total inpatient days (column 3). The percentage of time that interns and residents are assigned to the SNF is included in column 1, line 2, for adults and pediatrics. The program days are reimbursed through Worksheet E-2. (See 42 CFR 413.24(d)(5) and CMS Pub. 15-I, §2230.5B.)

Column 2--Enter on line 1 the total cost of services rendered in all patient care areas from Worksheet B, Part I, column 27, line 70. Multiply the amount in column 1 by the total cost in column 2, line 1. Enter the resulting amounts on the appropriate lines in column 2.

Inpatient

Column 3--Enter the total inpatient days applicable to the various patient care areas of the complex.

<u>Description</u>	<u>Enter in Col. 3</u>	<u>Inpatient Days From Worksheet D-1</u>
Adults & Pediatrics	line 2	Part I, col. 1, line 1
Intensive Care Unit	line 3	Part II, col. 2, line 43
Coronary Care Unit	line 4	Part II, col. 2, line 44
Burn Intensive Care Unit	line 5	Part II, col. 2, line 45
Surgical Intensive Care Unit	line 6	Part II, col. 2, line 46
Other Intensive Care Type Unit	line 7	Part II, col. 2, line 47
Nursery	line 8	S-3, Part I, col. 6, line 11
Subprovider	line 10	Part I, col. 1, line 1
SNF	line 12	Part I, col. 1, line 1
NF	line 13	Part I, col. 1, line 1

Column 4--Divide the allocated expenses in column 2 by the inpatient days in column 3 to arrive at the average per diem cost for each cost center.

For swing bed-SNF or swing bed-NF facilities, transfer the per diem amount in column 4, line 2, to Worksheet E-2, column 1 (for titles V and XIX) or column 2 (for title XVIII), line 4.

Columns 5, 6, and 7--Enter in the appropriate column the health care program inpatient days for each patient care area.

Titles V and XIX

<u>Description</u>	<u>Enter in column 5 for title V or column 7 for title XIX</u>	<u>From Worksheet D-1</u>
Adults & Pediatrics Intensive Care Unit	line 2	Part I, col. 1, line 9
Coronary Care Unit	line 3	Part II, col. 4, line 43
Burn Intensive Care Unit	line 4	Part II, col. 4, line 44
Surgical Intensive Care Type Unit	line 5	Part II, col. 4, line 45
Other Intensive Care Type Unit	line 6	Part II, col. 4, line 46
Nursery	line 7	Part II, col. 4, line 47
Subprovider I	line 8	Part II, col. 4, line 42
SNF	line 10	Part I, col. 1, line 9
NF	line 12	Part I, col. 1, line 9
	line 13	Part I, col. 1, line 9

Title XVIII--Enter in column 6, lines 2 through 12, as appropriate, the total number of days in which beneficiaries were inpatients of the provider and had Medicare Part B coverage. Such days are determined without regard to whether Part A benefits were available. Submit a reconciliation with the cost report demonstrating the computation of Medicare Part B inpatient days. The following reconciliation format is recommended:

<u>Cost Center</u>	<u>Part A Inpatient Days</u>	<u>plus</u>	<u>Part B Only Days</u>	<u>minus</u>	<u>Part A Coverage But No Part B Days</u>	<u>=</u>	<u>Part B Medicare Days</u>
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Part A Inpatient Days--Enter the Medicare Part A inpatient days from Worksheet D-1.

<u>Cost Center</u>	<u>From Worksheet D-1</u>
Adults & Pediatrics Intensive Care Unit	Part I, column 1, line 9
Coronary Care Unit	Part II, column 4, line 43
Burn Intensive Care Type Unit	Part II, column 4, line 44
Surgical Intensive Care Type Unit	Part II, column 4, line 45
Other Intensive Care Type Unit	Part II, column 4, line 46
Subprovider	Part II, column 4, line 47
Skilled Nursing Facility	Part I, column 1, line 9
	Part I, column 1, line 9

Part B Only Days--Enter the total number of days from your records in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

No Part B Days--Enter the total number of days from your records in which inpatients were covered under Medicare Part A but did not have Part B benefits available.

Columns 8, 9, and 10--Multiply the average cost per day in column 4 by the health care program days in columns 5, 6, and 7, respectively. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Outpatient

Column 3--Enter the total charges applicable to each outpatient service area. Obtain the total charges from Worksheet C, Part I, column 8, lines 60 through 63.

Column 4--Compute the total outpatient cost to charge ratio by dividing costs in column 2 by charges in column 3 for each cost center.

Columns 5, 6, and 7--Enter in these columns program charges for outpatient services. Do not include in Medicare charges any charges identified as MSP/LCC.

Titles V and XIX

<u>Description</u>	<u>Enter in col. 5 for title V or col. 7 for title XIX</u>	<u>Sum of</u>	
		<u>Worksheet D-4, col. 2</u>	<u>Worksheet D, Part V, sum of cols. 2-5 (& subscripts of col. 5)</u>
Clinic	line 20	line 60	line 60
Emergency	line 21	line 61	line 61
Observation Beds	line 22	line 62	line 62
Other Outpatient	line 23	line 63	line 63

Title XVIII

<u>Description</u>	<u>From</u>				
	<u>Worksheet D-4, Column 6, col. 2</u>	<u>Worksheet D, Part V cols. 2-5 (& subscripts of col. 5)</u>			<u>Less Part A Only Charges</u>
Clinic	line 20	line 60	plusline 60	minus	From
Emergency	line 21	line 61	plusline 61	minus	Provider
Observation Beds	line 22	line 62	plusline 62	minus	Records
Other Outpatient	line 23	line 63	plusline 63	minus	

NOTE: Submit a reconciliation worksheet with the cost report showing the computations used for the charges for column 6.

If you have subproviders, the amounts entered in these columns are the sum of the hospital and subprovider Worksheets D-4 and D, Part V.

Columns 8, 9, and 10--Compute program outpatient costs for titles V and XIX and title XVIII, Part B cost by multiplying the cost to charge ratio in column 4 by the program outpatient charges in columns 5, 6, and 7. Enter the resulting amounts in columns 8, 9, and 10, as appropriate, for each cost center.

Transfer program expenses.

From Title V (Column 8)/Title XIX (Column 10)

Hospital: Sum of lines 9 and 24 TO Worksheet E-3, Part III, line 3

Subprovider: line 10 TO Worksheet E-3, Part III, line 3

Other Nursing Facility: line 13 TO Worksheet E-3, Part III, line 3

From Title XVIII (Column 9) (only if Part II is not utilized)

Hospital: Sum of lines 9 and 24 TO Worksheet E, Part B, line 2

Subprovider: line 10 TO Worksheet E, Part B, line 2

Skilled Nursing Facility: line 12 TO Worksheet E, Part B, line 2

3623.2 Part II - In Approved Teaching Program (Title XVIII, Part B Inpatient Routine Costs Only).--This part provides for reimbursement for inpatient routine services rendered by interns and residents in approved teaching programs to Medicare beneficiaries who have Part B coverage and are not entitled to benefits under Part A. (See CMS Pub. 15-I, chapter 4, and §2120.) Do not complete this section unless you qualify for the new teaching hospital exception for graduate medical education payments in 42 CFR 413.77(e)(1). (8/1/2000s)

Column 1--Enter the amounts allocated in the cost finding process to the indicated cost centers. Obtain these amounts from Worksheet B, Part I, sum of the amounts in columns 22 and 23, as adjusted for any post stepdown adjustments applicable to interns and residents in approved teaching programs.

Column 2--Enter the adjustment for interns and residents costs applicable to swing bed services but allocated to hospital routine cost. Compute these amounts as follows:

Swing Inpatient = Bed Amount	Interns and Residents Costs Allocated to Adults & times Pediatrics	Total Swing Bed Divided Days By	Total Days
For line 27 (SNF)	Wkst. D-2, col. 1, line 26	Wkst. D-1, sum of lines 5 and 6	Wkst. D-1, line 1
For line 28 (NF)	Wkst. D-2, col. 1, line 26	Wkst. D-1, sum of lines 7 and 8	Wkst. D-1, line 1

The amount subtracted from line 26 must equal the sum of the amounts computed for lines 27 and 28.

If you have swing beds in your subprovider, subscript line 35 into 35.01 and 35.02 to adjust for swing bed costs. Compute the swing bed amounts as explained above except that the interns and residents costs allocated to adults and pediatrics (line 35) comes from Worksheet D-2, column 1, line 35. The amount subtracted from line 35 must equal the sum of the subscripted lines (35.01 and 35.02).

Column 3--Enter on lines 26 and 35 the amounts in column 1 minus the amount in column 2. Enter on line 27 the amount from column 2. Enter on lines 29 through 33 and 37 the amounts from column 1.

Column 4--Enter the total inpatient days applicable to the various patient care areas of the complex. (See instructions for Part I, column 3. For line 27, this is from Worksheet D-1, sum of lines 5 and 6.)

Column 5--Divide the allocated expense in column 3 by the inpatient days in column 4 to arrive at the average per diem cost for each cost center.

Column 6--Enter on lines 26, 27, 29 through 33, and 35 through 37, as applicable, the total number of days in which inpatients were covered under Medicare Part B but did not have Part A benefits available.

Column 7--Multiply the average per diem cost in column 5 by the number of inpatient days in column 6 to arrive at the expense applicable to title XVIII for each cost center. Transfer the amount on line 27, or lines 35.01 or 35.02 if you are a subprovider with a swing bed, to Worksheet E-2, column 2, line 6.

For columns 1, 3, and 7, enter on line 34 the sum of the amounts on line 26 plus the sum of the amounts on lines 29 through 33.

Transfer the expenses on lines 34, 35, and 37 to the appropriate lines on Part III, column 4, whenever you complete both Parts I and II.

However, when only Part II is completed, transfer the amount entered in column 7, lines 34, 35, and 37 to Worksheet E, Part B, line 2, as appropriate.

3623.3 Part III - Summary for Title XVIII (To be completed only if both Parts I and II are used)--Do not complete this section unless you qualify for the exception for graduate medical education payments in 42 CFR 413.86(e)(4)(I). This part is applicable to Medicare only and is provided to summarize the amounts apportioned to the program in Parts I and II. This part is completed only if both Parts I and II are used.

Transfer title XVIII expenses.

<u>Description</u>	<u>From Column 6</u>		
Hospital	Line 41	TO	Worksheet E, Part B, line 2
Subprovider	Line 42	TO	Worksheet E, Part B, line 2
SNF	Line 44	TO	Worksheet E, Part B, line 2

3624. WORKSHEET D-4 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

All providers must complete this worksheet (including CAHs) with the exception of RPCH components. (See Worksheet S-2, line 30.) At the top of the worksheet, indicate by checking the appropriate lines the health care program, provider component, and the payment system for which the worksheet is prepared. When reporting Medicare charges on the appropriate lines and columns, do not include Medicare charges identified as MSP/LCC.

Line Descriptions

Lines 25 through 30--Enter the program charges from the PS&R or your records (hospital only).

Line 31--Enter in column 2 the inpatient program charges for subproviders. For the subprovider component do not complete lines 25-30. For the Hospital component do not complete line 31.

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.

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

Line 101--Enter the total of the amounts in columns 2 and 3, lines 37 through 64 and 66 through 68.

In accordance with 42 CFR 413.53, this worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII, Part A, and XIX. Complete a separate copy of this worksheet for each subprovider, hospital-based SNF, swing bed-SNF, swing bed-NF, and hospital-based NF for titles V, XVIII, Part A, and XIX, as applicable. Enter the provider number of the component in addition to the hospital provider number when the worksheet is completed for a component.

NOTE: If you are a rural hospital with an attached SNF electing the optional swing bed reimbursement method, use the SNF component number. However, in this case, if you also have certified swing beds, use the swing bed-SNF component number instead of the SNF provider number on all applicable worksheets.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, Part I. The ratios in columns 10 and 11 of Worksheet C, Part I are used only 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) or PPS (see 42 CFR 412.1(a) through 412.125), respectively. Use the ratios in column 9 in all other cases.

NOTE: Make no entries in columns 1 and 3 for any cost center with a negative balance on Worksheet B, Part I, column 27. However, complete column 2 for such cost centers.

Column 2--Enter from the PS&R or your records the indicated program inpatient charges for the appropriate cost centers. The hospital program inpatient charges exclude inpatient charges for swing bed services. If gross combined charges for professional and provider components were used on Worksheet C, Part I to determine the ratios entered in column 1 of this worksheet, then enter gross combined charges applicable to each health care program in column 2. If charges for provider component only were used, then use only the health care program charges for provider component in column 2.

NOTE: Certified transplant centers (CTCs) have final settlement made based on the hospital's cost report. 42 CFR 413.40(c)(iii) states that organ acquisition costs incurred by hospitals approved as CTCs are reimbursed

on a reasonable cost basis. Other hospitals that excise organs for transplant are no longer paid for this activity directly by Medicare. They must receive payment from the organ procurement organization (OPO) or CTC. Therefore, hospitals which are not CTCs do not have any program reimbursable costs or charges for organ acquisition services. CTCs complete Worksheet D-6 for all organ acquisition costs.

Line 45--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §3610) for a more complete discussion on the use of this cost center.

NOTE: Since the charges on line 45 are also included on line 44, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 102.

Line 56--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Lines 60 through 63--Use these lines for outpatient service cost centers.

NOTE: For lines 60 and 63, any ancillary service billed as clinic, RHC, or FQHC services must be reclassified to the appropriate ancillary cost center, e.g., radiology - diagnostic, PBP clinical lab services - program only.

Lines 62 and/or 62.01, are completed for observation bed services if the patient was subsequently admitted as an inpatient, where applicable, for all hospitals, i.e., acute care hospitals, freestanding rehabilitation hospitals, psychiatric hospitals, etc. In a complex comprised of an acute care hospital with an excluded unit, the acute care hospital reports the observation bed costs. Subproviders with separate provider numbers from the main hospital (no alpha character in the provider number) may report observation bed costs if a separate outpatient department is maintained within the subprovider unit.

Line 61--Enter in column 2 the inpatient program charges for the subproviders' component only. For the subproviders component do not complete lines 25-30. For a Hospital complex do not complete line 31.

Lines 66 and 67--Do not enter program charges for oxygen rented or sold, because, effective with services rendered on or after June 1, 1989, the fee schedule applies.

Line 102--Enter in column 2 program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 45.

Line 103--Enter in column 2 the amount on line 101 less the amount on line 102.

Transfer the amount in column 2, line 103, as follows.

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part II, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, column 5, line 103, to Worksheet E-3, Part III, column 1, line 11.

NOTE: If the amount on line 103 includes charges for professional patient care services of provider-based physicians, eliminate the amount of the professional component charges from the total charges and transfer the net amount as indicated. Submit a schedule showing these computations with the cost report.

Column 3--Multiply the indicated program charges in column 2 by the ratio in column 1 to determine the program inpatient expenses.

Transfer column 3, line 101, as follows:

Type of Provider

TO

Hospital	Wkst. D-1, Part II, col. 1, line 48
Subprovider	Wkst. D-1, Part II, col. 1, line 48
SNF	Wkst. D-1, Part III, col. 1, line 80
NF	Wkst. D-1, Part III, col. 1, line 80
Swing Bed-SNF	Wkst. E-2, col. 1, line 3
Swing Bed-NF	Wkst. E-2, col. 1, line 3

3625. WORKSHEET D-6 - COMPUTATION OF ORGAN ACQUISITION COSTS AND CHARGES FOR HOSPITALS WHICH ARE CERTIFIED TRANSPLANT CENTERS

Only certified transplant centers (CTCs) are reimbursed directly by the Medicare program for organ acquisition cost. This worksheet provides for the computation and accumulation of organ acquisition costs and charges for CTCs. Check the appropriate box (heart, liver, lung, pancreas, intestine, kidney, islet, or other organs - specify) to determine which organ acquisition cost is being computed. Use a separate worksheet for each type of organ.

Hospitals that are not CTCs are not reimbursed by the Medicare program for organ acquisition costs and do not complete this worksheet. Such hospitals have to obtain revenue by the sale of any organs excised to an organ procurement organization (OPO) or CTC.

Worksheet D-6 consists of the following four parts:

- Part I - Computation of Organ Acquisition Cost (Inpatient Routine and Ancillary Services)
- Part II - Computation of Organ Acquisition Cost (Other than Inpatient Routine and Ancillary Service Costs)
- Part III - Summary of Costs and Charges
- Part IV - Statistics

3625.1 Part I - Computation of Organ Acquisition Costs (Inpatient Routine and Ancillary Services).--

Lines 1 through 7--These lines provide for the computation of inpatient routine service costs applicable to organ acquisition and for the accumulation of inpatient routine service charges for organ acquisition.

Column 1--Enter on lines 1 through 6, as appropriate, the inpatient routine charges applicable to organ acquisition. Enter on line 7 the sum of the amounts reported on lines 1 through 6.

Column 2--Enter on lines 1 through 6, as appropriate, the average per diem cost from Worksheet D-1:

<u>Description</u>	<u>To Worksheet D-6, Part I, Col. 2</u>	<u>From Worksheet D-1, Part II</u>
Adults & Pediatrics	line 1	col. 1, line 38
Intensive Care	line 2	col. 3, line 43
Coronary Care	line 3	col. 3, line 44
Burn Intensive Care Type Unit	line 4	col. 3, line 45
Surgical Intensive Care Type Unit	line 5	col. 3, line 46
Other Intensive Care Type Unit	line 6	col. 3, line 47

Column 3--Enter from your records on lines 1 through 6, as appropriate, total organ acquisition days (Medicare and non-Medicare). An organ acquisition day is an inpatient day of care rendered to an organ donor patient who is hospitalized for the surgical removal of an organ for transplant or a day of care rendered to a cadaver in an inpatient routine service area for the purpose of surgical removal of its organs for transplant. Enter on line 7 the sum of the days on lines 1 through 6.

Column 4--Enter on lines 1 through 6, as appropriate, the amount in column 2 multiplied by the amount in column 3. Enter on line 7 the sum of lines 1 through 6.

Lines 8 through 34--These lines provide for the computation of ancillary service cost applicable to organ acquisition. These lines also provide for the accumulation of inpatient and outpatient organ acquisition ancillary charges.

Column 1--Enter on lines 8 through 34 the "cost or other" cost to charges ratio from Worksheet C, Part I, column 9.

Column 2--Enter from your records inpatient and outpatient organ acquisition ancillary charges. Enter on line 35 the sum of lines 8 through 34.

Column 3--Enter on lines 8 through 34 the organ acquisition costs. Compute this amount by multiplying the ratio in column 1 by the amount in column 2 for each cost center. Enter on line 35 the sum of lines 8 through 34.

3625.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs).--

Lines 36 through 41--Use these lines to apportion the cost of inpatient services attributable to organ acquisitions rendered in each of the inpatient routine areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the average per diem cost of interns and residents not in an approved teaching program in each of the inpatient routine areas. Obtain these amounts from Worksheet D-2, Part I, column 4, lines as indicated.

Column 2--Enter the number of organ acquisition days in each of the inpatient routine areas from Part I, column 3, lines 1 through 6, as appropriate.

Column 3--Multiply the per diem amount in column 1 by the number of days in column 2 for each cost center.

Line 42--For columns 2 and 3, enter the sum of lines 36 through 41.

Lines 43 through 46--These lines provide for the computation of the cost of outpatient services attributable to organ acquisitions rendered in each of the outpatient service areas by interns and residents not in an approved teaching program.

Column 1--Enter on the appropriate lines the organ acquisition charges in each of the outpatient service areas. Obtain these amounts from Part I, column 2, lines 31 through 34, as appropriate.

Column 2--Enter the ratio of the outpatient costs of interns and residents not in an approved teaching program to the hospital outpatient service charges in each of the outpatient service areas. Obtain these ratios from Worksheet D-2, Part I, column 4, lines as indicated.

Column 3--Multiply the charges in column 1 by the ratios in column 2 for each cost center. Enter the sum of lines 43 through 46 on line 47.

3625.3 Part III - Summary of Costs and Charges.--

Line 48--Enter in column 1 the sum of the costs in Part I, column 4, line 7 and column 3, line 35. Enter in column 3 the sum of the charges in Part I, column 1, line 7 and column 2, line 35.

Line 49--Enter in column 1 the cost of inpatient services of interns and residents not in an approved teaching program from Part II, column 3, line 42. Enter in column 3 your charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 50--Enter in column 1 the cost of outpatient services of interns and residents not in an approved teaching program from Part II, column 3, line 47. Enter in column 3 the provider charges for the services for which the cost is entered in column 1. If you do not charge separately for the services of interns and residents, enter zero in column 3.

Line 51--Enter in column 1 the direct organ acquisition costs and allocated general service costs from Worksheet B, Part I, column 27, lines 82, 83, 84, or 85, whichever is applicable.

These direct costs include, but are not limited to, the cost of services purchased under arrangements or billed directly to you for:

- o Fees for physician services (preadmission donor and recipient tissue typing),
- o Costs for organs acquired from other providers or organ procurement organizations,
- o Transportation costs of organs,
- o Organ recipient registration fees,
- o Surgeon's fees for excising cadaveric organs, and
- o Tissue typing services furnished by independent laboratories.

NOTE: Transportation costs to ship organs outside of the United States are not an allowable cost.

If you have a schedule of charges which represents the various direct organ acquisition costs included in column 1, enter in column 3 the total of the charges which are applicable to the costs in column 1. However, if you have no such schedule of charges, enter the amount from column 1 in column 3.

Line 52--If you have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter in columns 1 and 3 the amount from Worksheet(s) D-9, Part II, column 3, lines 20, 21, 22, and 23.

Line 53--Enter in columns 1 and 3 the sum of lines 48 through 52. This amount must be equal to or greater than the amount reported on line 58 (revenues for organs sold).

For cost reporting periods beginning on or after September 15, 1997 there is no distinction to be made regarding the payment for kidney acquisition and all other organs.

For Kidney Acquisition Only (For cost reporting periods beginning on or after September 15, 1997 all organ acquisition costs are calculated similarly).

Line 54--Enter the number of total usable organs (this includes all kidneys except those that could not be transplanted).

Line 55--Enter total usable organs (line 54) less the sum of organs sent to military hospitals (without a reciprocal sharing agreement with the Organ Procurement Organization (OPO) in effect prior to March 3, 1988 and approved by the intermediary), to veterans' hospitals, organs sent outside the United States, and organs transplanted into non-Medicare beneficiaries. Include organs that had partial payments by a primary insurance payer in addition to Medicare. Do not include organs that were totally paid by primary insurance other than Medicare, as they are non-Medicare. Do not include organs procured from a non-certified OPO.

Line 56--Enter line 55 divided by line 54.

Line 57--Enter in column 1 the amount in column 2, line 56 multiplied by the amount in column 1, line 53. Enter in column 3 the amount in column 2, line 56 multiplied by the amount in column 3, line 53.

Line 58--Enter in columns 1 and 3 the total revenue applicable to:

- o Organs (included on line 55) furnished to other providers and organs sent to procurement organizations and others;
- o Organs sent to OPOs, military hospitals with a reciprocal sharing agreement with the OPO in effect prior to March 3, 1988, and approved by the intermediary, and organs sent to transplant centers; and
- o Organs that were partially reimbursed by another primary insurer other than Medicare and were included on line 55.

NOTE: When the primary payer makes a single payment for the transplant and acquisition, it is necessary to prorate the amount received between the transplant and the acquisition based on the charges submitted to the payer. Report the primary payer amounts applicable to organ transplants on Worksheet E, Part A, line 17. Report the primary payer amounts applicable to organ acquisition on this line.

Line 59--Enter the amount entered on line 57 minus the amount on line 58.

For Other Than Kidney Acquisitions (For cost reporting periods beginning on or after September 15, 1997, all organ acquisition costs are calculated similarly.) Refer to the instructions identified as kidney only for the reporting of all other organ acquisition costs and disregard the instructions for lines 53 through 59 below.

Lines 54 through 57--Do not complete these lines.

Line 58--Enter in columns 1 and 3 the total revenue applicable to organs furnished to other providers, to organ procurement organizations and others, and for organs transplanted into non-Medicare patients. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicare patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered on line 58 must also include an amount representing the acquisition cost of the organs transplanted into such patients. Determine this amount by multiplying the average cost of organ acquisition by the number of organs transplanted into non-Medicare patients who are not liable for payment on a charge basis.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisition) by the total number of organ transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 59--Enter line 53 minus line 58.

For All Organ Acquisitions

Line 60--Enter in all columns the total amount of organ acquisition charges billed to Medicare under Part B. This occurs when organs are transplanted into Medicare beneficiaries who, on the day of transplantation, are not entitled to Part A benefits. This computation reflects an adjustment between Medicare Part A and Part B costs and charges so that the amount added under Part B is the same amount subtracted under Part A.

Line 61--For columns 1 and 3 subtract line 60 from line 59. For columns 2 and 4 transfer that amount from line 60.

3625.4 Part IV - Statistics--

Lines 62 through 76--The data entered are data applicable to living donors (column 1) and cadaveric donors (column 2). Use column 1 (living related) for kidney, partial liver, and partial lung transplants. If you complete this worksheet for hearts, pancreases, intestines, whole livers, or whole lungs do not complete column 1.

Line 66--Enter the sum of lines 62 through 65.

Lines 67 through 74--Enter in columns 1 and 2 the appropriate number of organs sold (or transplanted). Enter in column 3 the revenue applicable to organs furnished to other providers, organ procurement organizations and others, and for organs transplanted into non-Medicare patients. Such revenues must be determined under the accrual method of accounting. If organs are transplanted into non-Medicare patients who are not liable for payment on a charge basis, and as such there is no revenue applicable to the related organ acquisitions, the amount entered on these lines must also include an amount representing the acquisition cost of the organs transplanted into such patients. Determine this amount by multiplying the average cost of organ acquisition by the number of organs transplanted into non-Medicare patients not liable for payment on a charge basis.

Compute the average cost of organ acquisition by dividing the total cost of organ acquisition (including the inpatient routine service costs and the inpatient ancillary service costs applicable to organ acquisitions) by the total number of organs transplanted into all patients and furnished to others. If the average cost cannot be determined in the manner described, then use the appropriate standard organ acquisition charge in lieu of the average cost.

Line 75--Enter in columns 1 and 2 the applicable number of unusable organs.

Line 76--Enter the sum of lines 67 through 75. These totals equal the totals on line 66, columns 1 and 2.

3626. WORKSHEET D-9 - APPORTIONMENT OF COST FOR SERVICES OF TEACHING PHYSICIANS

This worksheet provides for the computation of the RCE limit by medical specialty and for the apportionment of reimbursable adjusted cost to titles V, XVIII, and XIX for the direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in CMS Pub. 15-I, §2148.

NOTE: Do not complete this worksheet for an RPCH/CAH component.

If such election is made, direct medical and surgical services to program patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the hospital staff are reimbursable as provider services on a reasonable cost basis. In addition, certain medical school costs may be reimbursed. Payments for services donated by volunteer physicians to program patients are made to a fund designated by the organized medical staff the teaching hospital or medical school.

Limits on the amount of physician compensation which may be recognized as a reasonable provider cost are imposed in accordance with 42 CFR 405.482.

Worksheet D-9 consists of two parts:

- Part I - Reasonable Compensation Equivalent Computation
- Part II - Apportionment of Cost for the Services of Teaching Physicians

3626.1 Part I - Reasonable Compensation Equivalent Computation.--This part provides for the computation of the RCE limit by medical specialty of the physician on the hospital staff or physician on the medical school faculty. Complete separate parts for the hospital staff physicians and for physicians on the medical staff faculty. This part must be completed by applicable hospitals.

42 CFR 405.482(a)(2) provides that limits established under this section do not apply to costs of physician compensation attributable to furnishing inpatient hospital services paid for under the prospective payment system. (See 42 CFR Part 412.)

Limits established under this section apply to inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40), outpatient services for all titles, and to title XVIII, Part B inpatient services.

42 CFR 405.465 provides for the reimbursement of direct medical and surgical services to patients, including supervision of interns and residents, rendered in a teaching hospital by physicians on the faculty of a medical school where the hospital exercises the election as provided in 42 CFR 415.160.

Where several physicians work in the same specialty, see CMS Pub. 15-I, §2182.6C for a discussion of applying the RCE limit in the aggregate for the specialty versus on an individual basis to each of the physicians in the specialty.

When RCE limits are applied on an individual basis to each physician in a medical specialty, prepare a supporting worksheet identical in columnar format to Worksheet D-9, Part I, for each medical specialty. Enter on the first line under columns 1 and 9 the line number applicable to the medical specialty (as displayed on Worksheet D-9, Part I). Enter the name of the medical specialty.

on the first line in columns 2 and 10. Following the first line, use a separate line to compute the adjusted cost of physician's direct medical and surgical services (column 16) for each physician. Enter the total amount from column 16 of the supporting worksheet in column 16 of the line on Worksheet D-9, Part I, corresponding to the medical specialty for which the supporting worksheet is prepared. If the individual physician method is used, list each physician using an individual identifier that is not necessarily the name or social security number of the physician (e.g., Dr. A, Dr. B). However the identity of the physician must be made available to your fiscal intermediary.

NOTE: The method used on Worksheet D-9 (i.e., aggregate or individual physician) must be the same as the method used on Worksheet A-8-2.

Column Descriptions

Column 3--Enter for each medical specialty the amount of the total cost included in Worksheet A-8-2, column 3. When the individual physician method is used, enter in column 3 of the supporting worksheet the amount included on Worksheet A-8-2, column 3, for that physician.

Column 4--Enter for each medical specialty the amount of the cost included in Worksheet A-8-2, column 4, for the direct medical and surgical services, including the supervision of interns and residents by physicians on the hospital staff or by physicians on the faculty of a medical school, as appropriate.

If the individual physician method is used, enter in column 4 of the supporting worksheet the amount included on Worksheet A-8-2, column 4, for the indicated physician.

Column 5--Enter for each line of data the reasonable compensation equivalent (RCE) limit applicable to the physician's compensation. The amount entered is the limit applicable to the physician specialty as published in HCFA Pub. 15-I, §2182.6 before any allowable adjustments.

Section §2182.6.F of HCFA Pub. 15-I contains Table I - Estimates of FTE Annual Average Net Compensation Levels for 1984. Obtain the RCE applicable to the specialty from this table. If the physician specialty is not identified in the table, use the RCE for the total category in the table. The beginning date of the cost reporting period determines which calendar year (CY) RCE is used. Your location governs which of the three geographical categories are applicable: non-metropolitan areas, metropolitan areas less than one million, or metropolitan areas greater than one million.

Column 6--Enter the physician's hours allocated to professional services (i.e., professional component hours) in all components (e.g., hospitals, subproviders) of the health care complex. If the physician is paid for unused vacation, unused sick leave, etc., exclude the hours so paid from the hours entered in this column. Time records or other documentation that supports this allocation must be available for verification by your intermediary upon request. (See HCFA Pub. 15-I, §2182.3E.)

Column 7--Enter the unadjusted RCE limit for each line of data. This amount is the product of the RCE amount entered in column 5 and the ratio of the physician's professional component hours entered in column 6 to 2080 hours.

Column 8--Enter for each line of data five percent of the amounts entered in column 7.

Column 11--You may adjust upward, up to five percent of the computed limit (column 8), the computed RCE limit in column 7 to take into consideration the actual costs of membership for physicians in professional societies and continuing education paid by the provider or medical school.

Enter for each line of data the actual amounts of these expenses paid by the provider or medical school.

Column 12--Enter for each line of data the result of multiplying column 4 by column 11 and dividing by column 3.

Column 13--You may also adjust upward the computed RCE limit in column 7 to reflect the actual malpractice expense incurred by the provider or by the medical school, as appropriate, for the services of a physician or group of physicians to provider patients. In making this adjustment, your intermediary determines the ratio of that portion of compensated physician time spent in furnishing services in the provider (both to the provider and to provider patients) to the physician's total working time and adjusts the total malpractice expense proportionately.

Enter for each line of data the actual amounts of these malpractice expenses paid by the provider (or medical school, if applicable).

Column 14--Enter for each line of data the result of multiplying column 4 by column 13 and dividing by column 3.

Column 15--Enter for each line of data the sum of columns 7 and 14 plus the lesser of columns 8 or 12.

Column 16--Enter for each line of data the adjusted cost of direct medical and surgical services, including the supervision of interns and residents (i.e., the lesser of column 4 or column 15).

Line Descriptions

Line 11--Total the amounts in columns 3 through 8 and 11 through 16.

3626.2 Part II - Apportionment of Cost for Services of Teaching Physicians.-This part provides for the computation and apportionment of reimbursable cost to titles V, XVIII, and XIX for the adjusted direct medical and surgical services, including the supervision of interns and residents, rendered by physicians to patients in a teaching hospital which makes the election described in HCFA Pub. 15-I, §2148. Complete this part for the hospital and each subprovider.

Line Descriptions

Line 1--Enter in the appropriate column the adjusted cost of direct medical and surgical services, including the supervision of interns and residents, rendered to all patients by physicians on the hospital staff (column 1) and by physicians on the medical school faculty (column 2), as determined in accordance with HCFA Pub. 15-I, §2148. Transfer these amounts from Part I, column 16, line 11. Enter the same amount on each component's copy of Part II.

Line 2--Enter in column 1 the sum of the inpatient days and the outpatient visit days for all patients in the health care complex. Compute these days in the manner described in HCFA Pub. 15-I, §2218.C. Enter in column 2 the same number of days as entered in column 1. Make the same entries on each copy of Part II.

Line 3--Enter the result obtained by dividing the cost of services on line 1 by the sum of the days on line 2 for each category of physicians.

Lines 4 through 13--Enter in column 1, on the appropriate line, the reimbursable days and outpatient visit days for titles V, XVIII, and XIX for the applicable component of the health care complex. Lines 10, 11, 12, and 13 contain the total of the title XVIII organ acquisition days and outpatient visit days. Enter in column 2 the same number of days as entered in column 1. Compute these days from your records in the manner described in CMS Pub. 15-I, §2218.C.

Lines 14 through 23--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 13 by the average cost per diem from line 3. Enter the total of columns 1 and 2 in column 3 for each line. The total becomes a part of the reimbursement settlement through the transfers denoted on this worksheet.