

4024. WORKSHEET D - COST APPORTIONMENT

Worksheet D consists of the following five 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/Outpatient Ancillary Service Other Pass Through Costs
- Part V - Apportionment of Medical and Other Health Services Costs

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. CAHs do not complete Parts I through IV. Hospital based SNF and NF providers are added to the D, Part III and will also complete a separate Worksheet D, Part IV.

Line Descriptions for Parts I Through V

Lines 30 through 43 (for Parts I and III) and lines 44 and 45 (for Part III) and 50 through 98 (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. Therefore, any lines subscripted on those worksheets, must be subscripted on this worksheet.

4024.1 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 capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26.

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, Part I, 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 total patient days, excluding swing bed days, for that cost center. For line 30, enter the total days reported on Worksheet S-3, Part I, column 8, the sum of lines 1 and 28. For lines 31 through 43, enter the days from Worksheet S-3, Part I, column 8, lines 8 through 12, 13, and 16-18 (as applicable), respectively.

Column 5-- Divide the capital costs of each cost center in column 3 by the total patient days in column 4 for each line to determine the capital per diem cost. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the applicable cost centers. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, line 1. For lines 31 through 43, enter the days from Worksheet S-3, Part I, columns 5, 6, or 7 as appropriate, lines 8 through 12, 13, and 16-18 (as applicable), 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. 15-1, §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 30, and decrease the appropriate intensive care or other special care unit by those days.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs applicable to inpatient routine services, as applicable.

4024.2 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 26.

Column 1--Enter on each line the capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 1, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost to charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92 the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96 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--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

4024.3 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, hospital-based SNF and NF/ICF-MR (if applicable) information on the same worksheet, lines as appropriate. SNFs are now required to report medical education costs as a pass through cost.

Column 1--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no.

Column 2--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments reported on Worksheet B-2, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no.

Column 3--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, plus or minus post step down adjustments (reported on Worksheet B-2), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no. Otherwise do not transfer the costs.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1), because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs are reimbursed as a pass through based on reasonable cost.

Column 4--Compute the amount of the swing bed adjustment. If you have a swing bed agreement, determine the amount for the cost center in which the swing beds are located by multiplying the sum of the amounts in columns 1 through 3 by the ratio of the amount entered on Worksheet D-1, Part I, line 26 to the amount entered on Worksheet D-1, Part I, line 21.

Column 5--Enter the sum of columns 1 through 3 (including subscripts) minus column 4.

Column 6--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 4. For SNFs enter total patient days from Worksheet S-3, Part I, column 8, line 19.

Column 7--Enter the per diem cost for each line by dividing the cost of each cost center in column 5 by the total patient days in column 6.

Column 8--Enter the program inpatient days for the applicable cost centers. Transfer these amounts from the appropriate Worksheet D, Part I, column 6. For SNF (line 44) enter the program days from Worksheet S-3, Part I, column 6, line 19.

Column 9--Multiply the per diem cost in column 7 by the inpatient program days in column 8 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 30 through 35 and 43 to Worksheet D-1, Part I, line 50 for the hospital. If you are a title XVIII hospital paid under IPPS, also transfer this sum to Worksheet E, Part A, line 57. Transfer the amounts on lines 40 through 42 to the appropriate

Worksheet D-1, line 50 for the subprovider. Also transfer the amount on line 40 to Worksheet E-3, Part II, line 28 and the amount on line 41 to Worksheet E-3, Part III, line 29. For hospital-based SNF, NF or ICF/MR that follow Medicare principles, transfer the amount in column 9, line 44 to Worksheet E-3, Part VI, line 2 or for NF or ICF/MR to Worksheet E-3, Part VII, line 26, as applicable.

4024.4 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 IPPS must also direct medical education costs as these costs are reimbursed separately. Determine capital-related inpatient ancillary costs on Worksheet D, Part II. 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 or ICF/MR (if applicable). Hospital payment for outpatient services are 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 26.

Column 1--Transfer from Worksheet B, Part I, column 19 for each applicable line (plus or minus any adjustments reported on Worksheet B, Part I, column 25, if applicable) the nonphysician anesthesiologist's costs which qualify for a reasonable cost payment in accordance with 42 CFR 412.113(c). (See also §4013, line 19 description for more information.)

Column 2--Transfer from Worksheet B, Part I, column 20, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25, if applicable), the applicable medical education costs for nursing school when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 91.

Column 3--Transfer from Worksheet B, Part I, column 23, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25, if applicable), the applicable medical education costs for paramedical education (allied health) when Worksheet S-2, Part I, line 60 is yes. Do not transfer the costs if the response is no. For the hospital component only, enter on line 92 the observation bed amount from Worksheet D-1, Part IV, column 5, line 92.

Column 4--Transfer from Worksheet B, Part I, the sum of columns 21 and 22, for each applicable line, (plus or minus post step down adjustments made on Worksheet B, Part I, column 25), the applicable medical education costs for interns and residents when Worksheet S-2, Part I, line 57, column 1 is yes and column 2 is no, otherwise do not transfer the costs. For the hospital only, enter on line 92, observation beds, the amount from Worksheet D-1, Part IV, column 5, line 93.

NOTE: If you qualify for the exception in 42 CFR 413.77(e)(1) because this is the first cost reporting period in which you are training residents in approved programs and the residents were not on duty during the first month of this cost reporting period, then all direct graduate medical education costs for interns and residents in approved programs are reimbursed as a pass through based on reasonable cost.

Column 5--This column represents total inpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 1 through 4 and applicable subscripts.

Column 6--This column represents outpatient other pass-through costs. Enter on each appropriate line the sum of the amounts entered on the corresponding lines in columns 2, 3 and 4 and applicable subscripts.

Column 7--Enter on each line the charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7 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 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7 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 9.

Column 10--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

For hospitals, CAHs and subproviders transfer column 11, line 200 to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital or subprovider, also transfer this amount to Worksheet E, Part A, line 58. For SNFs for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3 or titles V and XIX, SNFs, NFs and ICF/MRs to Worksheet E-3, Part VII, line 26, as applicable.

Column 12--Enter on each line titles XVIII, Part B, V or XIX (if applicable) outpatient charges from Worksheet D, Part V, column 2 and applicable subscripts. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 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.

For hospitals, IPPS hospitals, CAHs and subproviders transfer column 13, line 200 to Worksheet E, Part B, line 9.

4024.5 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. Title XVIII is reimbursed in accordance with 42 CFR 413.53. For services rendered on and after August 1, 2000, outpatient services are subject to outpatient PPS.

Enter in the appropriate cost center the program charges from the PS&R or from provider records.

Providers exempt from outpatient PPS (i.e., CAHs), complete columns 3, 4, 6 and 7. All other providers subscript columns 2 and 5 as necessary. Include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis as indicated on line 73 below.

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.

NOTE: Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report only charges for CMHCs 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 5 through 7 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26. However, complete columns 1 through 4 for such cost centers.

In accordance with ACA, section 3121 as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108, the Temporary Payroll Tax Cut Continuation Act of 2011, section 308, and the Middle Class Tax Relief and Job Creation Act of 2012, section 3002, hold harmless payments are extended for rural hospitals with 100 or fewer beds through December 31, 2012; SCHs and EACHs regardless of bed size through February 29, 2012; and SCHs and EACHs with 100 or fewer beds through December 31, 2012. As such, rural hospitals and SCHs or EACHs that qualify and whose cost reporting period overlaps the effective date, (Worksheet S-2, Part I, line 120, column 1 or 2 is yes), must subscript column 2 and enter the applicable charges that correspond to the respective portion of the cost reporting period.

In accordance with ACA 2010, section 3138, cancer hospitals must utilize a predetermined payment to cost ratio (PCR) to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. The PCR may be revised each calendar year. Where the cost reporting period overlaps a PCR revision date, subscript column 2 and the corresponding column 5 to represent the portion of the cost reporting period that corresponds to each unique PCR. See section 4030.2 for further instruction/information.

Column 1--Enter on each line in column 1 the ratio from the corresponding line on Worksheet C, column 9.

Columns 2 through 4--General Instructions--Do not include in Medicare charges any charges identified as MSP/LCC.

Column 2--PPS Reimbursed Services--Enter the charges for services rendered which are 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. 2.01, 2.02) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and/or 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. The subscripting of this column will directly correspond to the subscripts of Worksheet E, Part B, lines 2 through 8.

Do not include in any column services excluded from OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab.

Column 3--Cost Reimbursed Services Subject to Deductibles and Coinsurance--Enter the charges for services rendered which are subject to cost reimbursement. This includes services rendered by CAHs.

Include the charges for drugs and supplies related to ESRD dialysis (excluding EPO and Aranesp, and any drugs or supplies paid under the composite rate), and corneal tissue on line 73.

Column 4--Cost Reimbursed Services Not Subject to Deductibles and Coinsurance--Vaccine Cost Apportionment--This column provides for the apportionment of costs which are not subject to deductible and coinsurance i.e., Pneumococcal, Influenza, Hepatitis B and Osteoporosis. Enter such charges for services which are not subject to deductible and coinsurance.

Column 5--Multiply the charges in column 2 and subscripts, if necessary, by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 6--Multiply the charges in column 3 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 7--Multiply the charges in column 4 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Line Descriptions

Line 60--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 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, 2010, but before July 1, 2012 (Patient Protection and Affordable Care Act of 2010, section 3122, amended by the MMEA, §109). For title V and XIX purposes, follow applicable State program instructions.

For CAHs, 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 61--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §4013 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 61 are also included on line 60, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 201.

Line 71--Enter in columns 2 and 3 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 72--Enter in columns 2 and 3 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.

Line 73--Enter the program charges for drugs charged to patients. Enter in column 2 charges for vaccines and drugs reimbursed at 100 percent under OPSS. Include in column 3 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. Include in column 4 vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance.

Line 74--The only renal dialysis services entered on this line are for inpatients that 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 3. Enter the related costs in column 6.

Line 75--Enter in column 3 the outpatient ASC facility charges and Part B 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.

Lines 88 - 93--Use these lines for outpatient service cost centers.

NOTE: For lines 88, 89 and 90, 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 92--Enter in column 2 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 94--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 95--For PPS hospital providers ambulance services are reimbursed under the ambulance fee schedule. As such, do not report charges for ambulance services rendered (column 2 for non PPS hospitals).

However, for CAHs eligible for cost reimbursement for ambulance services (billed as exempt from the ambulance fee schedule), charges for ambulance services on line 95 are transferred from your records or PS&R report type 85C. Enter charges in column 3 and multiply column 1 times column 3. Enter the result in column 6.

Lines 96 and 97--For title XVIII, DME is paid on a fee schedule through the contractor and, therefore, is not paid through the cost report.

Line 200--Enter the sum of lines 50 through 98.

Line 201--Enter in columns 3 and 4 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 61.

Line 202--Enter in columns 3, 4, 6 and 7 and subscripts, the amount on line 200 plus or minus the amounts on line 201, if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 3 and 4 and applicable subscripts, line 202 to Worksheet E, Part B, line 12 (ancillary services charges). Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than IPPS), transfer the sum of the amounts in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 plus the amount from Worksheet D-3, column 2, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

For titles V and XIX (under IPPS), transfer the amount in columns 2, 3 and /or 4 plus subscripts as applicable, line 202 to the appropriate Worksheet E-3, Part VII, line 9.

NOTE: If the amount on line 202 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>	Title XVIII, Part B <u>Swing Bed</u>	<u>To</u>	Titles V or XIX or Title XVIII, Part B
Column 6, line 202 and column 7, line 73 and subscripts	N/A		Wkst. E, Part B, col. 1 (& subscripts), line 1
Columns 5, line 202	N/A		Wkst. E, Part B, col. 1 (& subscripts), line 2
Sum of columns 2, 3 and 4 as applicable (SNF only), line 202	N/A		Wkst. E, Part B, line 12 or Wkst. E-3, Part VII, col. 1, line 9 for titles V or XIX
Sum of column 6 and 7 (SNF only) line 202	Wkst E-2 col. 2, line 3		Wkst. E, Part B, line 1 or Wkst. E-3, Part VII, col. 1, line 2 for titles V or XIX

4025. 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 (including CAH), 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, Other Nursing Facility, and ICF/MR Only
- Part IV - Computation of Observation Bed Pass Through 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. 15-1, §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 documented in 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. 15-1, §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. 15-1, §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. 15-1, §2217.)

Observation Beds--Observation beds, for purposes of this worksheet, are those beds in general routine areas of the hospital 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 34)). If you have a distinct observation bed unit (an outpatient cost center), report the costs of this unit on the subscripted line 92.01 on Worksheet A.

4025.1 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 8 for the component and lines as indicated: hospitals from lines 7 and 28; subproviders from lines 16 through 18, as applicable, and 28, if applicable; SNFs from line 19; and NFs from line 20. If you answered yes to line 92 of Worksheet S-2, the NF days come from line 19 for the SNF level of care and line 20 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.

Line 2--Enter the total general routine inpatient days. Include private room days and exclude swing bed and newborn days. Hospitals enter the sum of the days entered on Worksheet S-3, Part I, column 8, lines 1 and 28. 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 and observation bed days. If you have only private room days, do not complete this line.

Line 4--Enter the result of line 2, minus line 3, minus total observation bed days from Worksheet S-3, Part I, column 8, line 28. The result will be semi-private room days exclusive of swing bed semi-private room days and observation bed days. If you have only private room days, such days will be included in this line.

NOTE: For purposes of this computation, the program does not distinguish between semi-private and ward accommodations. (See CMS Pub. 15-1, chapter 22, §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 5, column 8.

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 6, column 8.

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. 5, 6, or 7, line 1
Subprovider applicable	Wkst. S-3, Part I, cols. 5, 6, or 7, line 16, 17, or 18 as applicable
SNF	Wkst. S-3, Part I, cols. 5, 6, or 7, line 19
NF	Wkst. S-3, Part I, cols. 5, 6, or 7, for SNF only level of care; line 19. If line 92 of Wkst S-2, Part I is a "Y", two D-1s must be completed for title XIX using line 19 for SNF level of care and line 20 for the NF level of care; or line 20 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. 15-1, chapter 22, §2217.)

NOTE: If Worksheet S-2, line 92 columns 1 or 2, as applicable is “Y” for yes, then Worksheet D-1 for title XIX (for the SNF and NF component) must be completed. The results are to be combined and transferred to title XIX SNF, Worksheet E-3, Part VII, line 1.

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 8, line 13.

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 5 and 7, respectively, line 13.

Lines 17 - 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 contractor.

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. 15-1, chapter 22, §2230ff.) Critical access hospitals do not complete this line.

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. 15-1, chapter 22, §2230ff.) Critical access hospitals do not complete this line.

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 contractor.

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 contractor.

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 30 for adults and pediatrics or lines 40, 41, or 42, as applicable for the subprovider, as appropriate:

COST or OTHER	Inpatient - Column 1 (includes CAHs)
TEFRA	Inpatient - Column 3 (includes cancer and children's hospitals)
PPS	Inpatient - Column 5 (includes acute, IPFs, IRFs, & LTCHs)

SNF/NF Inpatient Routine--For title XVIII, transfer this amount from Worksheet C, Part I, column 5, line 44 (SNF). For titles V and XIX, transfer this amount from Worksheet B, Part I, column 26, line 45 (NF) or 45.01 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, 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, 64 and 65). 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 - 36--All providers must complete lines 28 through 36. PPS providers complete these lines for data purposes only. However, if line 4 equals line 2 above or if line 3 above is zero, 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 and observation bed days (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 and observation bed days (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 4 equals line 2, enter the amount from line 27 above.

4025.2 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.

CAHs are also required to complete this worksheet.

Line Descriptions

Line 38--For non-IPPS providers, (includes CAHs), 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, IPFs, 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 43.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF, and LTCH PPS	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 31 through 35, as appropriate.

TEFRA, COST, or OTHER Inpatient	Column 3
PPS Inpatient, or IPF, IRF and LTCH PPS	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 8, lines 8 through 12, 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 5, 6, or 7, as appropriate, lines 8 through 12.

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. 15-1, §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-3, column 3, line 200.

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 V, line 1 or Part VII, line 1, as appropriate. Do not complete lines 50-63.

For all inclusive rate providers (Method E) apply the percentage to the sum of the aforementioned lines (lines 41 through 48) based on the provider type designated on Worksheet S-2, column 4, line 3 (see CMS Pub. 15-1, 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, column 7, sum of lines 30 through 35 and line 43 for the hospital, and line 40, 41, or 42, as applicable, for the subprovider. Add that amount to the other pass through costs from Worksheet D, Part III, column 9, sum of lines 30 through 35 and line 43 for the hospital, and line 40, 41, or 42, as applicable, 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, column 5, line 200. Add that amount to the other pass through costs from Worksheet D, Part IV, column 11, line 200.

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 63--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.) CAHs do not complete these lines as reimbursement is based on reasonable cost. The following hospitals are reimbursed under special provisions and, therefore, are not generally subject to TEFRA or prospective payment:

- Hospitals reimbursed under approved State cost control systems (see 42 CFR 403.300 through 403.322);
- 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 63.

NOTE: A new non-PPS hospital or subprovider (Lines 85 and/or 86 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. 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 14 and 16 through 18 (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 contractor. 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 62--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 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 62. New providers skip lines 58 through 62 and go to line 63.

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 15 percent of line 57 or 2 percent of line 56. If line 57 is negative, do not complete line 58 (leave blank), however, complete line 62 for calculation of any adjustments to the operating costs.

Line 59--Enter the inpatient operating cost per discharge updated and compounded by the market basket for each year through the current reporting year.

Line 60--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 61--If (line 53/line 54) is less than the lower of lines 55, 59 or 60, enter the lesser of 50 percent of the amount by which operating costs (line 53) are less than expected costs (line 54 times line 60), or 1 percent of the target amount (line 56); otherwise enter zero. (42 CFR 413.40(d)(4)(i))

Line 62--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. (42 CFR 413.40(d)(3))

Line 63--Allowable Cost Plus incentive Payment--If line 57 is a positive amount, enter the sum of lines 52, 53, 58 and 61 (if applicable). If line 57 is a negative amount enter the sum of lines 52, 56, and 62. 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.

Line 64--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 CAHs multiply line 10 times the per diem calculated on line 38.

Line 65--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 CAHs multiply line 11 times the per diem calculated on line 38.

Line 66--Enter the sum of lines 64 and 65. For CAHs only transfer this amount to Worksheet E-2, column 1, line 1.

Line 67--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 68--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 69--Enter the sum of lines 67 and 68. 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 66.

4025.3 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. Hospital-based SNFs complete lines 70 through 74 and 83 through 86 for data purposes only as SNFs are reimbursed under SNF PPS for title XVIII. Complete lines 70-89 for titles V and XIX. 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.

Line Descriptions

Line 70--Enter the hospital-based SNF or other nursing facility routine service cost from Part I, line 37.

Line 71--Calculate the adjusted general inpatient routine service cost per diem by dividing the amount on line 70 by inpatient days, including private room days, shown on Part I, line 2.

Line 72--Calculate 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 71.

Line 73--Calculate 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 74--Add lines 72 and 73 to determine the total reasonable program general inpatient routine service cost.

Lines 75 - 82--Apportionment of Inpatient Operating Costs for Other Nursing Facilities (NF)--These lines are used for titles V and/or XIX only. For title XVIII Medicare, skip lines 75 through 82 and continue with line 83.

Line 75--Enter the capital-related cost allocated to the general inpatient routine service cost center. For titles V and XIX, transfer this amount from Worksheet B, Part II, column 26, line 45 (NF).

Line 76--Calculate the per diem capital-related cost by dividing the amount on line 75 by the days in Part I, line 2.

Line 77--Calculate the program capital-related cost by multiplying line 76 by the days in Part I, line 9.

Line 78--Calculate the inpatient routine service cost by subtracting line 77 from line 74.

Line 79--Enter the aggregate charges to beneficiaries for excess costs obtained from your records.

Line 80--Enter the total program routine service cost for comparison to the cost limitation. Obtain this amount by subtracting line 79 from line 78.

Line 81--Enter the inpatient routine service cost per diem limitation. This amount is provided by your state contractor.

Line 82--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 81.

Line 83--For titles V and XIX, enter the amount of reimbursable inpatient routine service cost determined by adding line 77 to the lesser of line 80 or line 82. If you are a provider not subject to the inpatient routine service cost limit, enter the sum of lines 77 and 80. For title XVIII, enter the amount from line 74.

Line 84-- Enter the program ancillary service amount from Worksheet D-3, column 3, line 200.

Line 85--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, line 25. 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 25.

Line 86--Calculate the total program inpatient operating cost by adding the amounts on lines 83 through 85. Transfer this amount to the appropriate Worksheet E-3, Part VII, line 1 except for SNFs subject to SNF PPS. For NF and ICF/MR, transfer this amount to Worksheet E-3, Part VII, line 1 for titles V and XIX.

4025.4 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 only in the general acute care routine area of the hospital. For title XIX, insert the amount calculated for title XVIII for the hospital, if applicable. To avoid duplication of reporting observation bed costs, do not transfer the title XIX amount to Worksheet C.

Line 87--Transfer the total observation bed days from Worksheet S-3, Part I, column 8, line 28. NOTE: Observation days are only recognized and reported in the inpatient routine area of the hospital.

Line 88--Calculate the result of general inpatient routine cost on line 27 divided by line 2.

Line 89--Multiply the number of days on line 87 by the cost per diem on line 88 and enter the result. Transfer this amount to Worksheet C, Parts I and II, column 1, line 92.

Lines 90 - 93--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. Lines 90 through 93 correspond to specific medical education programs reported on Worksheet D, Part III, columns 1, 2, and 3, respectively.

Column 1--For line 90, transfer the amount from Worksheet D, Part I, column 1, line 30 for the hospital. For line 91 through 93, enter the cost from Worksheet D, Part III, columns 1, 2 and 3, line 30.

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 89. 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 90	Col. 1, line 92	
Col. 5, line 91		Col. 2, line 92
Col. 5, line 92		Col. 3, line 92
Col. 5, line 93		Col. 4, line 92

4026. WORKSHEET D-2 - APPORTIONMENT OF COST OF SERVICES RENDERED BY INTERNS AND RESIDENTS

4026.1 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. 15-1, chapter 4.) If you have more than one hospital-based outpatient rehabilitation provider, subscript line 17 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 19 and 21 through 26 (from your records).

Column 2--Enter on line 1 the total cost of services rendered in all patient care areas from Worksheet B, Part I, column 26, line 100. 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 Intensive Care Unit	line 2	Part I, col. 1, line 1
Coronary Care Unit	line 3	Part II, col. 2, line 43
Burn Intensive Care Unit	line 4	Part II, col. 2, line 44
Surgical Intensive Care Unit	line 5	Part II, col. 2, line 45
Other Intensive Care Type Unit	line 6	Part II, col. 2, line 46
Nursery	line 7	Part II, col. 2, line 47
IPF - Inpatient Routine	line 8	S-3, Part I, col. 8, line 13
Subprovider	line 10	Part I, col. 1, line 1
SNF	line 11	Part I, col. 1, line 1
NF	line 12	Part I, col. 1, line 1
	line 13	Part I, col. 1, line 1
	line 14	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
IPF - Inpatient Routine	line 8	Part II, col. 4, line 42
IRF - Inpatient Routine	line 10	Part I, col. 1, line 1
Subprovider	line 11	Part I, col. 1, line 1
SNF	line 12	Part I, col. 1, line 1
NF	line 13	Part I, col. 1, line 1
	line 14	Part I, col. 1, line 1

Title XVIII--Enter in column 6, lines 2 through 13, 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 plus Days</u>	<u>Part B Only Days</u>	<u>minus</u>	<u>Part A Coverage But No Part B = Days Coverage</u>	<u>Medicare Part B Days</u>
--------------------	-----------------------------------	-------------------------	--------------	--	-----------------------------

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
IPF - Inpatient Routine	Part II, column 4, line 47
IRF - Inpatient Routine	Part I, column 1, line 9
Subprovider	Part I, column 1, line 9
Skilled Nursing Facility	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, column 8, lines 88 through 93.

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>	Enter in col. 5 for title V or col. 7 for title XIX	<u>Sum of</u>	
		<u>Worksheet D-3, col. 2</u>	<u>Worksheet D, Part V, sum of cols. 2 - 4 (& applicable subscripts)</u>
RHC	line 21	line 88	line 88
FQHC	line 22	line 89	line 89
Clinic	line 23	line 90	line 90
Emergency	line 24	line 91	line 91
Observation Beds	line 25	line 92	line 92
Other Outpatient	line 26	line 93	line 93

Title XVIII:

<u>Description Charges</u>	Enter in col. 6 for Title XVIII	<u>From</u>			
		<u>Worksheet D-3, col. 2</u>	<u>Worksheet D, Part V cols. 2 - 4 (& applicable subscripts)</u>		<u>Less Part A Only</u>
RHC	line 21	line 88	plus	line 88 minus	
FQHC	line 22	line 89	plus	line 89 minus	From
Clinic	line 23	line 90	plus	line 90 minus	Provider
Emergency	line 24	line 91	plus	line 91 minus	Records
Observation Beds	line 25	line 92	plus	line 92 minus	
Other Outpatient	line 26	line 93	plus	line 93 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-3 and D, Part V.

Columns 8, 9, and 10, lines 21-26--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 27	TO	Worksheet E-3, Part VII, line 19
Subprovider: lines 10-12, as applicable	TO	Worksheet E-3, Part VII, line 19
Other Nursing Facility: line 14	TO	Worksheet E-3, Part VII, line 19

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

Hospital: Sum of lines 9 and 27	TO	Worksheet E, Part B, line 22
Subprovider: line 10-12, as applicable	TO	Worksheet E, Part B, line 22
Skilled Nursing Facility: line 13	TO	Worksheet E, Part B, line 22

4026.2 Part II - In An 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. 15-1, 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).

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 21 and 22, 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 & Pediatrics	times	Total Swing Bed Days	divided by	Total Days
For line 30 (SNF)	Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 5 and 6		Wkst. D-1, line 1
For line 31 (NF)	Wkst. D-2, col. 1, line 29		Wkst. D-1, sum of lines 7 and 8		Wkst. D-1, line 1

The amount subtracted from line 29 must equal the sum of the amounts computed for lines 30 and 31.

If you have swing beds in your IPF subprovider, complete line 38 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 38) comes from Worksheet D-2, column 1, line 38. The amount subtracted from line 38 must equal the sum of subscripts of line 38, as applicable. If you have swing beds in your IRF subprovider, complete line 39 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 39) comes from Worksheet D-2, column 1, line 39. The amount subtracted from line 39 must equal the sum of subscripts of line 39, as applicable.

Column 3--Enter on lines 29 and 38 through 40, as applicable, the amounts in column 1 minus the amount in column 2. Enter on line 30 the amount from column 2. Enter on lines 32 through 36 and 41 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 30, 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 29, 30, 32 through 36, and 38 through 41, 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 30, or lines 38 through 40 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 37 the sum of the amounts on line 29 plus the sum of the amounts on lines 32 through 36.

Transfer the expenses on lines 37 through 41 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 37 through 41 to Worksheet E, Part B, line 22, as appropriate.

4026.3 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 413.77(e)(1). 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 45	TO	Worksheet E, Part B, line 22
Subprovider	Line 46-48	TO	Worksheet E, Part B, line 22
SNF	Line 49	TO	Worksheet E, Part B, line 22

4027. WORKSHEET D-3 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

This worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII and XIX as indicated in 42 CFR 413.53. All hospital filing a full cost report, including CAHs (Worksheet S-2, line 105 is marked "Y") must complete this worksheet. Complete a separate copy of this worksheet for each sub-provider, distinct part SNF and NF, swing-bed SNF and NF, or any other component. Identify the health care program, provider component, and the payment system by checking the appropriate boxes at the top of the worksheet.

The cost centers on this worksheet 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.

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94 and 96 through 98. The ratios in columns 10 and 11 of Worksheet C are used only for hospital or subprovider components for titles V, XVIII, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412, Subpart N, O, or P), respectively. Use the ratios in column 9 in all other cases.

Column 2--Enter from the PS&R or your records the inpatient program charges applicable to the provider component services only (not professional component) in the appropriate cost centers as detailed below. Also include charges for cost centers with a negative balance on Worksheet B Part I, column 26. Do not include program charges for swing bed services and Medicare charges identified as MSP/LCC.

Lines 30 - 35--Enter the program charges from the PS&R or your records (hospital only).

Lines 40 - 42--Enter in column 2 the inpatient program charges for the subproviders' component only. For subprovider components do not complete lines 30-35 and 43. For a Hospital complex do not complete lines 40-42.

Line 43--Enter the charges for your nursery department for which you were reimbursed. Complete this for Medicaid services only.

Line 61--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §4013) for a more complete discussion on the use of this cost center.

NOTE: Since the charges on line 61 are also included on line 60, laboratory, you must reduce total charges to prevent double counting. Make this adjustment on line 201.

Line 73--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Lines 88 - 90 and 93--Do not enter on these lines program charges related to any inpatient ancillary services (e.g., radiology- diagnostic, laboratory) provided in a clinic, RHC, or FQHC and billed as inpatient services. Instead, reclassify such program charges to the related ancillary cost centers.

Lines 92 and 92.01--Enter on these lines, as applicable, the program charges for observation bed services if the patient was subsequently admitted as an inpatient. However, these program charges can only be reported on the main hospital's (e.g., acute care hospital, freestanding psychiatric hospital, freestanding rehabilitation hospital) Worksheet D-3. (That is, program charges for observation bed services provided to patients subsequently admitted as inpatients to an acute hospital's excluded psychiatric or rehabilitation unit must be reported on Worksheet D-3 of the acute hospital.)

Lines 96 and 97--Do not enter program charges for oxygen rented or sold as the fee schedule applies for these services.

Line 200--Enter the total of the amounts in columns 2 and 3, lines 50 through 94 and 96 through 98.

Line 201--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 61.

Line 202--Enter in column 2 the amount on line 200 less the amount on line 201.

Transfer the amount in column 2, line 202, as follows.

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part V, 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, sum of columns 3 and 4, line 202, to Worksheet E-3, Part VII, column 1, line 9.

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 200, 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 84

NF

Wkst. D-1, Part III, col. 1, line 84

Swing Bed-SNF

Wkst. E-2, col. 1, line 3

Swing Bed-NF

Wkst. E-2, col. 1, line 3

4028. WORKSHEET D-4 - 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-4 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

4028.1 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-4, 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 - 40--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 40 the "cost or other" cost to charges ratio from Worksheet C, column 9.

Column 2--Enter from your records inpatient and outpatient organ acquisition ancillary charges. Enter on line 41 the sum of lines 8 through 40.

Column 3--Enter on lines 8 through 40 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 41 the sum of lines 8 through 40.

4028.2 Part II - Computation of Organ Acquisition Costs (Other Than Inpatient Routine and Ancillary Service Costs)--

Lines 42 - 47--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 48--For columns 2 and 3, enter the sum of lines 42 through 47.

Lines 49 - 54--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 35 through 40, 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 49 through 54 on line 55.

4028.3 Part III - Summary of Costs and Charges--

Line 56--Enter in column 1 the sum of the costs in Part I, column 4, line 7 and column 3, line 41. Enter in column 3 the sum of the charges in Part I, column 1, line 7 and column 2, line 41.

Line 57--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 48. 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 58--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 55. 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 59--Enter in column 1 the direct organ acquisition costs and allocated general service costs from Worksheet B, Part I, column 26, lines 105, 106, 107, 108, 109, 110, or 111, 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:

- Fees for physician services (preadmission donor and recipient tissue typing),
- Costs for organs acquired from other providers or organ procurement organizations,
- Transportation costs of organs,
- Organ recipient registration fees,
- Surgeon's fees for excising cadaveric organs, and
- 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 60--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-5, Part II, column 3, lines 24 through 31, as applicable.

Line 61--Enter in columns 1 and 3 the sum of lines 56 through 60. This amount must be equal to or greater than the amount reported on line 66 (revenues for organs sold).

Line 62--Enter the number of total usable organs (this includes all organs applicable to this worksheet except those that could not be transplanted). For islets since the number of islets cells injected into a recipient will vary depending on the patient, enter the number of patients who received islets injections. Each patient is allowed a maximum of two islet injections per inpatient stay.

Line 63--Enter total usable organs (line 62) 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 contractor), 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 64--Enter line 63 divided by line 62.

Line 65--Enter in column 1 the amount in column 2, line 64 multiplied by the amount in column 1, line 61. Enter in column 3 the amount in column 2, line 64 multiplied by the amount in column 3, line 61.

Line 66--Enter in columns 1 and 3 the total revenue applicable to:

- o Organs (included on line 63) 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 contractor, 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 63

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 60. Report the primary payer amounts applicable to organ acquisition on this line.

Line 67--Enter the amount entered on line 65 minus the amount on line 66.

Line 68--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 69--For columns 1 and 3 subtract line 68 from line 67. For columns 2 and 4 transfer that amount from line 68.

4028.4 Part IV - Statistics.--

Lines 70 - 84--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, whole lungs, or islets do not complete column 1.

Line 74--Enter the sum of lines 70 through 73.

Lines 75 - 82--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 83--Enter in columns 1 and 2 the applicable number of unusable organs.

Line 84--Enter the sum of lines 75 through 83. These totals equal the totals on line 74, columns 1 and 2.

4029. WORKSHEET D-5 - APPORTIONMENT OF COST FOR THE 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. 15-1, §2148.

NOTE: CAHs do not complete this worksheet.

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 415.70.

Worksheet D-5 consists of two parts:

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

4029.1 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 415.70(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 415.162 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. 15-1, §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-5, 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-5, 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-5, 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 contractor.

NOTE: The method used on Worksheet D-5 (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 CMS Pub. 15-1, §2182.6 before any allowable adjustments.

Obtain the RCE applicable to the specialty from the table listed in the FR, Vol. 68, No. 148, page 45488, dated Friday, August 1, 2003. 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 contractor upon request. (See CMS Pub. 15-1, §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 contractor 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.

4029.2 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 CMS Pub. 15-1, §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 CMS Pub. 15-1, §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 CMS Pub. 15-1, §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 17--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 through 17 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. 15-1, §2218.C.

Lines 18 through 31--Enter on the appropriate line the result of multiplying the days entered on lines 4 through 17 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.