

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

This worksheet consists of five parts:

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

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

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

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

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

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

Column Descriptions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Line Descriptions

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

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

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

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

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

Transfer Referencing

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

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

To

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

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

Ratios

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

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

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

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

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

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

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

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