

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

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

Line Descriptions

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

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

Lines 37 through 68--These cost centers have the same line numbers as the respective cost centers on Worksheets A, B, B-1, and C. This design facilitates referencing throughout the cost report.

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

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

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

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

Column 1--Enter the ratio of cost to charges developed for each cost center from Worksheet C, Part I. The ratios in columns 10 and 11 of Worksheet C, Part I are used only for hospital or subprovider components for titles V, XVIII, Part A, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412.1(a) through 412.125), respectively. Use the ratios in column 9 in all other cases.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Transfer column 3, line 101, as follows:

Type of Provider

TO

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