

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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