

**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. REHs do not complete the Worksheet D-1 series.

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/IID 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, chapter 22, §2230.9B.)

\* Hospitals, including CAHs, that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D-1, Parts I and II; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D-1, Parts I and II, for the portion of the cost reporting period, included in the demonstration. Select the "Hospital" box and complete a separate Worksheet D-1, Parts I and II, for the portion of the cost reporting period not included in the demonstration.

### 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, chapter 22, §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 42 CFR 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, chapter 22, §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, chapter 22, §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 sub-intensive 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/IID. 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, and observation bed 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, 6.01 (PARHM only), or 7, line 1
Subprovider	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 through 27--These lines provide for the carve-out of reasonable cost of extended care services furnished by a swing-bed hospital. Under the carve out method, the total costs attributable to SNF-type and NF-type routine services furnished to all classes of patients are subtracted from total general inpatient routine service costs before computing the average cost per diem for general routine hospital care. The rates on lines 17 through 20 are supplied by your 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.) CAHs 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.) CAHs 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 individuals with intellectual disabilities) 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 individuals with intellectual disabilities) 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/IID).

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 CAHs, 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 through 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. CAHs are required to complete this worksheet. 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.

\* Hospitals, including CAHs, that (1) participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete Worksheet D-1, Parts I and II; or (2) participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet D-1, Parts I and II, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet D-1, Parts I and II, for the portion of the cost reporting period not included in the demonstration.