

4023. WORKSHEET C - COMPUTATION OF RATIO OF COST TO CHARGES AND OUTPATIENT CAPITAL REDUCTION

4023.1 Part I - Computation of Ratio of Cost to Charges.--This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services, and other reimbursable services. All charges entered on this worksheet must comply with CMS Pub. 15-1, chapter 22, §§2202.4 and 2203. This ratio is used on Worksheet D, Part V, for titles V and XIX, and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, 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 IPPS, TEFRA, or other.

42 CFR 413.106(f)(3) 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 412 (inpatient prospective payment). However, therapy services furnished under arrangements to CAHs are subject to the provisions of 42 CFR 413.106.

42 CFR 415.70(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 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)(3) and 42 CFR 415.70(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 the IPPS or TEFRA (e.g., hospital-based SNFs and CAHs). Also use this ratio for Part B services still subject to cost reimbursement. In column 10, compute a TEFRA inpatient ratio. This ratio reflects the add-back of respiratory therapy/physical therapy (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 an IPPS inpatient ratio. This ratio reflects the add-back of RT/PT and RCE limitations to total cost since inpatient hospital services covered by the IPPS 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:

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

All components or portions of components not subject to IPPS, IPF PPS, IRF PPS, LTC PPS, or TEFRA, e.g., CAH services, are classified as "Cost or Other."

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

<u>Type of Service Inpatient</u>	<u>Columns</u>		
	<u>Cost or Other</u>	<u>TEFRA Inpatient</u>	<u>IPPS, IPF-PPS, IRF-PPS</u>
Inpatient routine service cost centers (lines 30-46)	1-3	1-3	1-5

<u>Type of Service Inpatient (Cont.)</u>	<u>Columns</u>		
	<u>Cost or Other</u>	<u>TEFRA Inpatient</u>	<u>IPPS, IPF-PPS, IRF-PPS</u>
Inpatient ancillary (lines 50-93)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 94-98)	1, 8, 9	1-3, 8-10	1-9, 11
Other Reimbursable (lines 99-101)	1, 8	1-3, 8	1-8
Special Purpose (lines 105-117)	1, 8	1-3, 8	1-8

Column 1--Enter on each line the amount from the corresponding line of Worksheet B, Part I, column 26. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, if you do not have a distinct observation bed area. If you have a distinct observation bed area, subscript line 92 into line 92.01, and transfer the appropriate amount from Worksheet B, Part I, column 26. In a complex comprised of an acute care hospital with an excluded unit(s) (excluded from the IPPS), only the acute care hospital may report observation bed costs. 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 88 and 89. Do not bring forward any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the amount of therapy limits applied to the cost center on lines 65 to 68. Obtain these amounts from Worksheet A-8, lines 23, 24, 30, and 31 respectively.

NOTE: Complete this column only when the hospital or subprovider is subject to PPS or TEFRA rate of increasing ceiling (see 42 CFR 412, Subparts N and P, and 42 CFR 413.40, respectively). 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 IPPS, IPF PPS, IRF PPS, or LTC 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 a 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 charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics, and orthotics). Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, column 26, and, therefore, do not contain "cost" in column 1 of Worksheet C, Part I.

Total charges on Worksheet C, Part I, for each department are for provider services only. Therefore, Medicare charges on Worksheets D, Parts II and IV, D-2, D-3, and D-4, 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 CMS Pub. 15-1, chapter 22, §2203.)

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 CMS Pub. 15-1, chapter 23, §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 §4013. All cost centers for which CRNA costs are excluded on Worksheet A-8 must also exclude the charges associated with these costs.

NOTE: Any charges for ancillary services provided to clinic, RHC and FQHC patients must be reclassified to the appropriate ancillary cost center, e.g., radiology-diagnostic, laboratory. A similar adjustment must be made to program charges.

Report on line 92 all charges for observation bed services provided in the inpatient routine care area of the hospital. The 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 bed unit, report your gross charges on line 92.01 (which was subscripted on Worksheet A).

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

Column 9 through 11--Cost to charge ratios are not calculated for lines 99 through 117. The corresponding locations on Worksheet C, Part I, are shaded.

Column 9, lines 50 through 98--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, lines 50 through 98--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, lines 50 through 98--Complete this section only when the hospital is subject to the IPPS or the LTC PPS or when its subprovider is subject to its respective PPS reimbursement methodology. (See 42 CFR 412.1(a) through 412.125, and 42 CFR 412, Subparts O, N, and P, respectively). 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 30 through 117--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 subscripted any lines on those worksheets, you must subscript the same lines on this worksheet.

NOTE: The worksheet line numbers start at line 30 because of the line referencing feature.

Line 200--For each of the columns 1 through 5 (total costs), respectively, enter the sum of lines 30 through 199 for all unshaded lines in accordance with Worksheet C, Part I.

For each of the columns 6, 7, and 8 (total charges), respectively, enter the sum of lines 30 through 60, and 62 through 199, for all unshaded lines in accordance with Worksheet C, Part I. Since the charges on line 61 are also included on line 60 (laboratory), the charges on line 61 must be excluded to avoid overstating total charges.

Line 201--Enter the amounts from line 92 for columns 1, 3, and 5. Calculate the observation bed cost on line 92 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 30 for the hospital. Therefore, in order to arrive at the total allowable costs, subtract this cost to avoid reporting these costs twice.

Line 201, columns 6, 7, and 8, are shaded.

Line 202--For columns 1, 3, and 5, subtract line 201 from line 200, and enter the result.

Transfer Referencing

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

<u>From Worksheet C, Column 1, 3, or 5:</u>	<u>To</u>
Line 30	Wkst. D-1, Part I, line 21
Lines 31 through 35	Wkst. D-1, Part II, lines 43 through 47
Line 40, 41, 42 and subscripts	Separate Wkst. D-1, Part I, line 21
Line 43 (titles V and XIX only)	Wkst. D-1, Part II, line 42
Line 44 (title XVIII only)	Separate Wkst. D-1, Part I, line 21
Line 45 and subscripts (titles V and XIX only)	Separate Wkst. D-1, Part I, line 21

Charges--Transfer the total charges for each of lines 50 through 98, column 8, to Worksheet D, Part IV, column 7, lines as appropriate.

Ratios

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

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

TEFRA Inpatient Ratio--Transfer the TEFRA inpatient ratio on lines 50 through 94 and lines 96 through 98 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-3, column 1, for each cost center.

PPS Inpatient Ratio--Transfer the PPS inpatient ratio on lines 50 through 94 and lines 96 through 98 from column 11, for hospital or subprovider components for titles V; XVIII, Part A; and XIX; inpatient services subject to the IPPS (see 42 CFR 412.1(a) through 412.125) to Worksheet D-3, column 1, for each cost center. The transfer of the PPS inpatient ratio also applies when the facility is an IPF subject to IPF PPS, a LTCH subject to LTCH PPS, or an IRF subject to IRF PPS (see 42 CFR 412, Subparts N, O, and P, respectively).

4023.2 Part II - Calculation of Outpatient Services Cost-to-Charge Ratios Net of Reductions for Medicaid Only.--This worksheet is not applicable for title XVIII. It is only applicable for select state Medicaid programs. This worksheet computes the outpatient cost-to-charge ratios reflecting the following:

- The percentage of capital reduction as identified on Worksheet S-2, Part I, line 95, the applicable column.
- The reduction in reasonable costs of hospital outpatient services (other than the capital-related costs of such services (also known as operating reduction)) is based upon the percentage entered on Worksheet S-2, Part I, line 97, the applicable column.

Column Descriptions

Column 1--Enter the amounts for each cost center from Worksheet B, Part I, column 26, as appropriate. Transfer the amount on line 92 from Worksheet D-1, Part IV, line 89, for the hospital and if you use inpatient routine beds as observation beds. If you have a distinct observation bed area, add subscripted line 92.01 and transfer the appropriate amount from Worksheet B, Part I, column 26. Do not bring forward costs in any cost center with a credit balance from Worksheet B, Part I, column 26.

Column 2--Enter the sum of the amounts for each cost center from Worksheet B, Part II, as appropriate. Do not bring forward costs in any cost center with a credit balance on Worksheet B, Part I, or Worksheet B, Part II. For line 92, enter the amounts from Worksheet D-1, Part IV, column 5, line 90. Combine the hospital and subprovider amounts if applicable.

Column 3--For each line, subtract column 2 from column 1 and enter the result.

Column 4--Multiply column 2 by the appropriate capital reduction percentage, and enter the result.

Column 5--Multiply column 3 by the outpatient reasonable cost reduction percentage and enter the result.

Column 6--Subtract columns 4 and 5 from column 1 and enter the result.

Column 7--Enter the total charges from Worksheet C, Part I, column 8.

Column 8--Divide column 6 by column 7 and enter the result.

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 or PARHM Demonstration, and the payment system, as applicable, for which the part is prepared.