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

NOTE: Only hospital components subject to PPS or TEFRA complete Worksheet D, Parts I through IV. New children's and new cancer hospitals complete only Worksheet D, Parts III and IV (line 85 of Worksheet S-2, Part I, has a "Y" response). CAHs do not complete Parts I through IV. Hospital-based SNF and NF providers are added to the Worksheet D, Part III, and will also complete a separate Worksheet D, Part IV.

Line Descriptions for Parts I through V

Lines 30 through 43 (for Parts I and III), lines 44 and 45 (for Part III), and *lines* 50 through 98 (for Parts II, IV, and V)--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. Therefore, any lines subscripted on those worksheets, must subscripted on this worksheet.

4024.1 Part I - Apportionment of Inpatient Routine Service Capital Costs--This part computes the amount of capital-related costs applicable to hospital inpatient routine service costs. Complete only one Worksheet D, Part I, for each title. Report hospital and subprovider information on the same worksheet, lines as appropriate. Complete this part for all payment methods.

Column 1--Enter on each line the capital-related cost for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26.

Column 2--Compute the amount of the swing-bed adjustment. If you have a swing-bed agreement or have elected the swing-bed optional method of reimbursement, determine the amount for the cost center in which the swing-beds are located by multiplying the amounts in column 1 by the ratio of the amount entered on Worksheet D-1, line 26, to the amount entered on Worksheet D-1, Part I, line 21.

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

Column 4--Enter on each line the total patient days, excluding swing-bed days, for that cost center. For line 30, enter the total days reported on Worksheet S-3, Part I, column 8, the sum of lines 1 and 28. For lines 31 through 43, enter the days from Worksheet S-3, Part I, column 8, lines 8 through 12, 13, and 16 through 18 (as applicable).

Column 5-- Divide the capital costs of each cost center in column 3 by the total patient days in column 4 for each line to determine the capital per diem cost. Enter the resultant per diem cost in column 5.

Column 6--Enter the program inpatient days for the applicable cost centers. For line 30, enter the days reported on Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, line 1. For

lines 31 through 43, enter the days from Worksheet S-3, Part I, columns 5, 6, or 7, as appropriate, lines 8 through 12, 13, and 16 through 18 (as applicable), 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. 15-1, chapter 22, §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 30, and decrease the appropriate intensive care or other special care unit by those days.

Column 7--Multiply the per diem in column 5 by the inpatient program days in column 6 to determine the program's share of capital costs applicable to inpatient routine services, as applicable.

4024.2 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 26.

Column 1--Enter on each line the capital-related costs for each cost center, as appropriate. Obtain this amount from Worksheet B, Part II, column 26. For the hospital component or subprovider, if applicable, enter on line 92 the amount from Worksheet D-1, Part IV, column 1, line 90.

Column 2--Enter on each line the total charges applicable to each cost center as shown on Worksheet C, Part I, column 8.

Column 3--Divide the capital cost of each cost center in column 1 by the charges in column 2 for each line to determine the cost-to-charge ratio. Round the ratios to six decimal places, e.g., round 0321514 to .032151. Enter the resultant departmental ratio in column 3.

Column 4--Enter on each line the appropriate title V; XVIII, Part A; or XIX, inpatient charges from Worksheet D-3, column 2. For title XVIII, enter on line 92, the observation bed charges applicable to title XVIII patients subsequently admitted after being treated in the observation area. Enter on line 96, 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--Multiply the capital ratio in column 3 by the program charges in column 4 to determine the program's share of capital costs applicable to titles V; XVIII, Part A; or XIX, inpatient ancillary services, as appropriate.