

Column 8--Divide the cost of each cost center in column 5 by the charges in column 7, 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 8.

Column 9--This column computes the outpatient ratio of cost to charges. Divide the cost of each cost center in column 6 by the charges in column 7, 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 9.

Column 10--Enter on each line titles V, XVIII, Part A, or XIX inpatient charges from Worksheet D-3. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 11--Multiply the ratio in column 8 by the charges in column 10 to determine the program's share of pass-through costs applicable to titles V, XVIII, Part A, or XIX inpatient ancillary services, as appropriate.

For hospitals and subproviders, transfer column 11, line 200, to Worksheet D-1, Part II, column 1, line 51. If you are an IPPS hospital, also transfer this amount to Worksheet E, Part A, line 58. If you are an IPF or IPF subprovider, also transfer this amount to Worksheet E-3, Part II, line 28. If you are an IRF or IRF subprovider, also transfer this amount to Worksheet E-3, Part III, line 29. For SNFs, for title XVIII transfer the amount on line 200 to Worksheet E-3, Part VI, line 3; or titles V and XIX, SNFs, NFs and ICF/IIDs to Worksheet E-3, Part VII, line 26, as applicable.

Column 12--Enter on each line titles XVIII, Part B, V or XIX (if applicable), outpatient charges from Worksheet D, Part V, column 2, and applicable subscripts. Do not include in Medicare charges any charges identified as MSP/LCC.

Column 13--Multiply the ratio in column 9 by the charges in column 12 to determine the program's share of pass-through costs applicable to titles XVIII, Part B, V or XIX (if applicable) outpatient ancillary services, as appropriate.

For providers subject to the OPPTS, transfer column 13, line 200, to Worksheet E, Part B, line 9.

4024.5 Part V - Apportionment of Medical and Other Health Services Costs--This worksheet provides for the apportionment of costs applicable to hospital outpatient services reimbursable under titles V, XVIII, and XIX. Title XVIII is reimbursed in accordance with 42 CFR 413.53. For services rendered on and after August 1, 2000, outpatient services are subject to the OPPTS.

Enter in the appropriate cost center the program charges from the PS&R or from provider records.

Providers exempt from outpatient PPS (i.e., CAHs), complete columns 3, 4, 6, and 7. All other providers subscript columns 2 and 5 as necessary. Include charges for vaccine, i.e., pneumococcal, flu, hepatitis, and osteoporosis as indicated on line 73 below.

Exclude charges for which costs were excluded on Worksheet A-8. For example, CRNA costs reimbursed on a fee schedule are excluded from total cost on Worksheet A-8. For titles V and XIX, enter the appropriate outpatient service charges.

**NOTE:** Do not enter CORF, OPT, OSP, OOT, or CMHC charges on Worksheet D, Part V. Report only charges for CMHCs on Worksheet J-2.

For title XVIII, complete a separate Worksheet D, Part V, for each provider component as applicable. Enter the applicable component number in addition to the hospital provider number. Make no entries in columns 5 through 7 of this worksheet for any cost centers with a negative balance on Worksheet B, Part I, column 26. However, complete columns 1 through 4 for such cost centers.

In accordance with ACA, section 3121, as amended by the Medicare and Medicaid Extenders Act (MMEA) of 2010, section 108; the Temporary Payroll Tax Cut Continuation Act of 2011, section 308; and, the Middle Class Tax Relief and Job Creation Act of 2012, section 3002; hold harmless payments are extended for rural hospitals with 100 or fewer beds through December 31, 2012; SCHs and EACHs regardless of bed size through February 29, 2012; and SCHs and EACHs with 100 or fewer beds through December 31, 2012. As such, rural hospitals and SCHs or EACHs that qualify and whose cost reporting period overlaps the effective date, (Worksheet S-2, Part I, line 120, column 1 or 2, is yes), must subscript column 2 and enter the applicable charges that correspond to the respective portion of the cost reporting period.

In accordance with ACA 2010, section 3138, cancer hospitals must utilize a predetermined payment-to-cost ratio (PCR) to calculate the corresponding transitional outpatient payment effective for services rendered beginning January 1, 2012. The PCR may be revised each calendar year. Where the cost reporting period overlaps a PCR revision date, subscript column 2 and the corresponding column 5 to represent the portion of the cost reporting period that corresponds to each unique PCR. See section 4030.2 for further instruction/information.

Column 1--Enter on each line in column 1 the ratio from the corresponding line on Worksheet C, column 9.

Columns 2 through 4--General Instructions--Do not include in Medicare charges any charges identified as MSP/LCC.

Column 2--PPS Reimbursed Services--Enter the charges for services rendered which are subject to PPS. These charges should not include services paid under the fee schedule such as physical therapy, speech pathology or occupational therapy. Create separate subscripted column (e.g. 2.01, 2.02) when a cost reporting period overlaps the effective dates for the various transitional corridor payments and/or when a provider experiences a geographic reclassification from urban to rural. However, no subscripting is required when a provider geographically reclassifies from rural to urban. The subscripting of this column will directly correspond to the subscripts of Worksheet E, Part B, lines 2 through 8.

Do not include in any column services excluded from the OPPS because they are paid under another fee schedule, e.g., rehabilitation services and clinical diagnostic lab.

Column 3--Cost Reimbursed Services Subject to Deductibles and Coinsurance--Enter the charges for services rendered which are subject to cost reimbursement. This includes services rendered by CAHs.

Include the charges for drugs and supplies related to ESRD dialysis (excluding ESAs, and any drugs or supplies paid under the composite rate or ESRD PPS bundled payment rate), and corneal tissue on line 72.

Column 4--Cost Reimbursed Services Not Subject to Deductibles and Coinsurance--Vaccine Cost Apportionment--This column provides for the apportionment of costs which are not subject to deductible and coinsurance i.e., Pneumococcal, Influenza, Hepatitis B, and Osteoporosis. Enter such charges for services which are not subject to deductible and coinsurance.

Column 5--Multiply the charges in column 2, and subscripts, if necessary, by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 6--Multiply the charges in column 3 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Column 7--Multiply the charges in column 4 by the ratios in column 1, and enter the result. Line 200 equals the sum of lines 50 through 98.

Line Descriptions

Line 60--Generally, for title XVIII, Medicare outpatient covered clinical laboratory services are paid on a fee basis, and should not be included on this line. Outpatient CAH clinical laboratory services will be paid on a reasonable cost basis not subject to deductibles and coinsurance. In addition, hospital outpatient laboratory testing by a hospital laboratory with fewer than 50 beds in a qualified rural area will also be paid on a reasonable cost basis not subject to deductibles and coinsurance, for cost reporting periods beginning on or after July 1, 2010, but before July 1, 2012 (Patient Protection and Affordable Care Act of 2010, §3122, amended by the MMEA, §109). For title V and XIX purposes, follow applicable State program instructions.

For CAHs, outpatient clinical laboratory diagnostic tests are paid at 101 percent of reasonable costs, and the beneficiary is not required to be physically present in the CAH at the time the specimen is collected. As such, enter the corresponding charges on this line. See MIPPA 2008, §148 and CR 6395, transmittal 1729, dated May 8, 2009.

Line 61--Enter the program charges for provider clinical laboratory tests for which the provider reimburses the pathologist. See §4013 for a more complete description on the use of this cost center. For title XVIII, do not include charges for outpatient clinical diagnostic laboratory services. For titles V and XIX purposes, follow applicable State program instructions.

**NOTE:** Since the charges on line 61 are also included on line 60, laboratory, reduce the total charges to prevent double counting. Make this adjustment on line 201.

Line 71--Enter in columns 2 and 3, the charges for medical supplies charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 72--Enter in columns 2 and 3, the charges for implantable devices charged to patients which are not paid on a fee schedule. Do not report the charges for prosthetics and orthotics.

Line 73--Enter the program charges for drugs charged to patients. Enter in column 2, charges for vaccines and drugs reimbursed at 100 percent under the OPSS. Include in column 3, charges for drugs paid at 80 percent of cost subject to deductibles and coinsurance, such as osteoporosis drugs and drugs paid under the OPSS such as hepatitis vaccines. Include in column 4, vaccine charges for vaccines reimbursed at 100 percent of cost such as pneumococcal and influenza vaccines not subject to deductibles and coinsurance.

Line 74--The only renal dialysis services entered on this line are for inpatients that are not reimbursed under the composite rate regulations. (See 42 CFR 413.170.) Therefore, include only inpatient Part B charges on this line in column 3. Enter the related costs in column 6.

Line 75--Enter in column 3 the outpatient ASC facility charges and Part B charges for the hospital non-distinct part ASC. These charges represent the ASC facility charge only (i.e., in lieu of operating or recovery room charges), and do not include charges for the ancillary services provided to the patient.

Lines 88 through 93--Use these lines for outpatient service cost centers.

**NOTE:** For lines 88, 89, and 90, 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. A similar adjustment must be made to program charges.

Line 92--Enter in column 2 the title XVIII Part B charges for observation beds. These are the charges for patients who were treated in the non-distinct observation beds and released. These patients were not admitted as inpatients.

Line 94--The only home program dialysis services which are cost reimbursed are those rendered to beneficiaries who have elected the option to deal directly with Medicare. Home program dialysis services reimbursed under the composite rate regulation (see 42 CFR 413.170) are not included on this line. This line includes costs applicable to equipment-related expenses only.

Line 95--Only CAHs eligible for cost reimbursement for ambulance services complete this line. Report charges for ambulance services from your records or the PS&R report type 85C in column 3. Multiply column 1 times column 3 and enter the result in column 6. All other hospital provider types are reimbursed under the ambulance fee schedule and do not complete this line.

Lines 96 and 97--For title XVIII, DME is paid on a fee schedule through the contractor and, therefore, is not paid through the cost report.

Line 200--Enter the sum of lines 50 through 98.

Line 201--Enter in columns 3 and 4 program charges for provider clinical laboratory tests where the physician bills the provider for program patients only. Obtain this amount from line 61.

Line 202--Enter in columns 3, 4, 6, and 7, and subscripts, the amount on line 200 plus or minus the amounts on line 201, if applicable.

Transfer Referencing: For title XVIII, transfer the sum of the amounts in columns 3 and 4, and applicable subscripts, line 202 to Worksheet E, Part B, line 12 (ancillary services charges). Make no transfers of swing bed charges to Worksheet E-2 since no LCC comparison is made.

For titles V and XIX (other than IPSS), transfer the sum of the amounts in columns 2, 3, and /or 4, plus subscripts as applicable, line 202, plus the amount from Worksheet D-3, column 2, line 202, to the appropriate Worksheet E-3, Part VII, line 9.

For titles V and XIX (under IPSS), transfer the amount in columns 2, 3, and /or 4, plus subscripts as applicable, line 202, to the appropriate Worksheet E-3, Part VII, line 9.

**NOTE:** If the amount on line 202 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.

#### Transfer References

	Title XVIII, Part B Swing Bed	to	Titles V or XIX or Title XVIII, Part B
From Wkst. D, Part V			
Column 6, line 202 and column 7, line 73, and subscripts	N/A		Wkst. E, Part B, col. 1 (and subscripts), line 1
Columns 5, line 202	N/A		Wkst. E, Part B, col. 1 (and subscripts), line 2
Sum of columns 2, 3, and 4, as applicable (SNF only), line 202	N/A		Wkst. E, Part B, line 12, or Wkst. E-3, Part VII, col. 1, line 9, for titles V or XIX
Sum of column 6 and 7 (SNF only), line 202	Wkst E-2, col. 2, line 3		Wkst. E, Part B, line 1, or Wkst. E-3, Part VII, col. 1, line 2, for titles V or XIX

## 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.

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.)

### 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.)