4027. WORKSHEET D-3 - INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

This worksheet provides for the apportionment of cost applicable to hospital inpatient services reimbursable under titles V, XVIII and XIX as indicated in 42 CFR 413.53. All hospitals (*) filing a full cost report, including CAHs (Worksheet S-2, line 105, is "Y") must complete this worksheet. Complete a separate copy of this worksheet for each subprovider, distinct part SNF and NF, swing-bed SNF and NF, or any other component. Identify the health care program, provider component, and the payment system by checking the appropriate boxes at the top of the worksheet.

The cost centers on this worksheet 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.

* Hospitals that participated in the PARHM demonstration must complete Worksheet D-3, for the portion of the cost reporting period not included in the PARHM demonstration and a separate Worksheet D-3, for the portion of the cost reporting period included in the PARHM demonstration.

Column 1--Effective for cost reporting periods ending before September 30, 2018, enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94, and 96 through 98. The ratios in columns 10 and 11 of Worksheet C are used only for hospital or subprovider components for titles V, XVIII, and XIX inpatient services subject to the TEFRA rate of increase ceiling (see 42 CFR 413.40) or PPS (see 42 CFR 412, Subpart N, O, or P), respectively. Use the ratios in column 9 in all other cases.

Effective for cost reporting periods ending on or after September 30, 2018, enter the ratio of cost to charges developed for each cost center from Worksheet C, lines 50 through 94, and 96 through 98. The ratios in column 10 of Worksheet C are used for TEFRA providers (see 42 CFR 413.40). TEFRA providers include LTCHs classified as extended neoplastic disease care hospitals; children's hospitals; cancer hospitals; RNHCIs; and hospitals located outside the 50 States, the District of Columbia, and Puerto Rico (i.e., hospitals located in the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa). The ratios in column 11 of Worksheet C are used for all PPS providers (see 42 CFR 412, Subpart N, O, or P; 42 CFR 413.114(a)(2) for other than CAHs; and 42 CFR 413, Subpart J). Use the ratios in column 9 for cost reimbursed providers such as CAHs, new TEFRA hospitals exempt from the rate of increase limits, and post-hospital SNF care furnished in a swing-bed CAH (see 42 CFR 413.114(a)(2)).

Column 2--Enter from the PS&R or your records the inpatient program charges applicable to the provider component services only (not professional component) in the appropriate cost centers as detailed below. Also include charges for cost centers with a negative balance on Worksheet B, Part I, column 26. Do not include Program charges for swing-bed services and Medicare charges identified as MSP/LCC. Hospitals that participated in the PARHM demonstration must report PS&R charges for the portion of the cost reporting period included in the PARHM demonstration and complete a separate worksheet and report PS&R charges for the portion of the cost reporting period not included in the demonstration.

Lines 30 through 35--Enter the program charges from the PS&R or your records (hospital only).

Lines 40 through 42--Enter inpatient program charges for the subproviders' component only. For subprovider components do not complete lines 30 through 35 and 43. For a hospital complex, do not complete lines 40 through 42.

Line 43--Enter the charges for your nursery department for which you were reimbursed. Complete this for Medicaid services only.

Line 61--Enter the program charges for your clinical laboratory tests for which you reimburse the pathologist. See the instructions for Worksheet A (see §4013) for a more complete discussion on the use of this cost center.

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

Line 73--Enter only the program charges for drugs charged to patients that are not paid a predetermined amount.

Line 77--For cost reporting period beginning prior to October 1, 2020, enter the HSCT charges billed under revenue code 0815. For cost reporting periods beginning on or after October 1, 2020, do not report charges billed under revenue code 0815 on this line; and report those charges in accordance with §4029.6.

Line 78--For CAR T-cell immunotherapy cost, enter the charges for services for all patients (for Medicare, these are billed under revenue codes 0871, 0872, 0873, 0874, and 0891).

Lines 88 through 90 and 93--Do not enter on these lines program charges related to any inpatient ancillary services (e.g., radiology- diagnostic, laboratory) provided in a clinic, RHC, or FQHC and billed as inpatient services. Instead, reclassify such program charges to the related ancillary cost centers.

Lines 92 and 92.01--Enter on these lines, as applicable, the program charges for observation bed services if the patient was subsequently admitted as an inpatient. However, these program charges can only be reported on the main hospital's (e.g., acute care hospital, freestanding psychiatric hospital, freestanding rehabilitation hospital) Worksheet D-3 or PARHM Demonstration Worksheet D-3. (That is, program charges for observation bed services provided to patients subsequently admitted as inpatients to an acute hospital's excluded psychiatric or rehabilitation unit must be reported on Worksheet D-3 of the acute hospital.)

Lines 96 and 97--Do not enter program charges for oxygen rented or sold as the fee schedule applies for these services.

Line 200--Enter the total of the amounts in columns 2 and 3, lines 50 through 94, and lines 96 through 98.

Line 201--Enter in column 2, program charges for your clinical laboratory tests when the physician bills you for program patients only. Obtain this amount from line 61.

Line 202--Enter in column 2, the amount on line 200 less the amount on line 201.

Transfer the amount in column 2, line 202, as follows:

For title XVIII, Part A (other reimbursement), transfer the amount to Worksheet E-3, Part V, line 8. Do not transfer this amount if you are reimbursed under PPS or TEFRA. No transfers of swing-bed charges are made to Worksheet E-2 since no LCC comparison is made. For titles V and XIX (if not a PPS provider), transfer the amount plus the amount from Worksheet D, Part V, sum of columns 3 and 4, line 202, to Worksheet E-3, Part VII, column 1, line 9.

Column 3--Multiply the indicated program charges in column 2, by the ratio in column 1, to determine the program inpatient expenses.

Transfer column 3, line 200, as follows:

Type of Provider	TO
Hospital	Wkst. D-1, Part II, col. 1, line 48
Subprovider	Wkst. D-1, Part II, col. 1, line 48
SNF	Wkst. D-1, Part III, col. 1, line 84
NF	Wkst. D-1, Part III, col. 1, line 84
Swing-Bed SNF	Wkst. E-2, col. 1, line 3
Swing-Bed NF	Wkst. E-2, col. 1, line 3