

ANALYSIS OF PAYMENTS TO PROVIDERS  
FOR SERVICES RENDERED

PROVIDER CCN:  
\_\_\_\_\_  
COMPONENT CCN:  
\_\_\_\_\_

PERIOD:  
FROM \_\_\_\_\_  
TO \_\_\_\_\_

WORKSHEET E-1,  
PART I

Check applicable box:  Hospital  Subprovider (Other)  PARHM Demonstration  
 IPF  SNF  PARHM CAH Swing-Bed SNF  
 IRF  Swing-Bed SNF

| Description  | Inpatient Part A    |        | Part B                    |        |      |
|--|---------------------|--------|---------------------------|--------|------|
|  | mm/dd/yyyy          | Amount | mm/dd/yyyy                | Amount |      |
|  | 1                   | 2      | 3                         | 4      |      |
| 1 Total interim payments paid to provider  |                     |        |                           |        | 1    |
| 2 Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write "NONE" or enter a zero                        |                     |        |                           |        | 2    |
| 3 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) | Program to Provider | .01    |                           |        | 3.01 |
|  |                     | .02    |                           |        | 3.02 |
|  |                     | .03    |                           |        | 3.03 |
|  |                     | .04    |                           |        | 3.04 |
|  |                     | .05    |                           |        | 3.05 |
|  | Provider to Program | .50    |                           |        | 3.50 |
|  |                     | .51    |                           |        | 3.51 |
|  |                     | .52    |                           |        | 3.52 |
|  |                     | .53    |                           |        | 3.53 |
|  |                     | .54    |                           |        | 3.54 |
| Subtotal (sum of lines 3.01- 3.49 minus sum of lines 3.50-3.98)  | .99                 |        |                           | 3.99   |      |
| 4 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)  |                     |        |                           |        | 4    |
| 5 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  | Program to Provider | .01    |                           |        | 5.01 |
|  |                     | .02    |                           |        | 5.02 |
|  |                     | .03    |                           |        | 5.03 |
|  | Provider to Program | .50    |                           |        | 5.50 |
|  |                     | .51    |                           |        | 5.51 |
|  |                     | .52    |                           |        | 5.52 |
| Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 -5.98)  | .99                 |        |                           | 5.99   |      |
| 6 Determined net settlement amount (balance due) based on the cost report (1)  | Program to Provider | .01    |                           |        | 6.01 |
|  | Provider to Program | .02    |                           |        | 6.02 |
| 7 Total Medicare program liability (see instructions)  |                     |        |                           |        | 7    |
| 8 Name of Contractor   | Contractor Number   |        | NPR Date (Month/Day/Year) |        | 8    |

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.