

4033.3 Part III - Calculation of Medicare Reimbursement Settlement Under IRF PPS--Use Worksheet E-3, Part III to calculate Medicare reimbursement settlement under IRF PPS for hospitals and subproviders. (See 42 CFR 412, subpart P.)

Use a separate copy of Worksheet E-3, Part III for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part III to indicate the component for which it is used. When the worksheet is completed for a component, show both the hospital and component numbers.

#### Line Descriptions

Line 1--Enter the net federal IRF PPS payment. The federal payment includes short stay outlier amounts. Exclude low income patient (LIP) and outlier payments. Obtain this information from the PS&R and/or your records.

In accordance with the 78 FR 47869 (August 6, 2013), effective for IRF discharges rendered on or after October 1, 2013, the IRF LIP adjustment factor is updated. Subscript column 1 for lines 1 and 3 for cost reporting periods that overlap October 1, 2013. Enter the net federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2013 in column 1 and the net federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2013 in column 1.01 to facilitate the calculation of the LIP adjustment on line 3, columns 1 and 1.01, respectively. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

Line 2--Enter the Medicare SSI ratio from your contractor as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit).

Line 3--Effective for cost reporting periods ending prior to October 1, 2013, enter the IRF LIP payment as the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .4613 \text{ power} - 1\}$  times (line 1). L1 = IRF Medicaid Days from Worksheet S-2, Part I, columns 1 through 6, line 25. L2 = IRF total days from Worksheet S-3, Part I, column 8, lines 1 or 17 as applicable plus employee discount days (Worksheet S-3, Part I, column 8, line 30 (line 31 for IRF subproviders)).

For cost reporting periods that overlap October 1, 2013, subscript column 1. To calculate the IRF LIP payment for discharges prior to October 1, 2013, enter in column 1 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .4613 \text{ power} - 1\}$  times (line 1, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2013, enter in column 1.01 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .3177 \text{ power} - 1\}$  times (line 1, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2013, enter in column 1 the result of  $\{(1 + (\text{line } 2) + (L1/L2)) \text{ to the } .3177 \text{ power} - 1\}$  times line 1.

Line 4--Enter the IRF outlier payment. Obtain this from the PS&R and/or your records.

**NOTE:** Complete only line 5 or line 6, but not both.

Line 5--For providers that trained residents in the most recent **cost reporting period ending on or before November 15, 2004** (response to Worksheet S-2, Part I, line 76, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period ending on or before November 15, 2004.

Line 5.01--For IRFs that qualify to receive a temporary adjustment to the FTE cap, enter the additional unweighted FTE count for residents that were displaced by program or hospital closure, which you would not be able to count without a temporary cap adjustment in accordance with 76 FR 47846 (August 5, 2011).

Line 6--If the response to Worksheet S-2, Part I, line 76, column 2, is “Y” and your facility did not train residents in the most recent cost reporting period ending on or before November 15, 2004, and qualifies to receive a cap adjustment (see 70 FR 47929 (August 15, 2005)) enter the new cap adjustment on this line. Do not complete this line until the new program growth period has ended using the method described in 42 CFR 413.79(e)(1)(i) and (ii). For new programs started prior to October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the cap adjustment accordingly. For facilities that participate in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), complete this line effective beginning with the facility’s cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (see 79 FR 50110 (August 22, 2014)).

Line 7--Enter the current year unweighted FTE resident count excluding FTEs in the new program growth period as determined using the method described in 42 CFR 413.79(e)(1)(i) and (ii). FTEs in the new program growth period are reported on line 8. If your fiscal year end does not correspond to the program year end and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, consistent with the regulations at 42 CFR 413.79(e)(1), include FTE residents in a new program on this line if this cost reporting period is the cost reporting period that coincides with or follows the start of the sixth program year of the first new program started (i.e., the initial years, see 79 FR 50110 (August 22, 2014)). Continue to report FTE residents on this line in subsequent cost reporting periods.

Line 8--Enter the current year unweighted FTE count for residents in the new program growth period. Complete this line only during the new program growth period of the first new program’s existence. For new programs started prior to October 1, 2012, if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program, then prorate the FTE count accordingly. For facilities that began participating in training residents in a new program for the first time on or after October 1, 2012, if your fiscal year end does not correspond to the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program, then prorate the FTE count accordingly.

Line 9--For providers that completed line 5, enter the lower of the FTE count on line 7 or the sum of the cap amounts on lines 5 and 5.01.

For providers that qualify to receive a cap adjustment (see 70 FR 47929 (August 15, 2005)), during the new program growth period of the first new program’s existence enter the FTE count from line 8.

For new programs started prior to October 1, 2012, beginning with the program year following the new program growth period of the first new program’s existence, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the fourth program year following the new program growth period of the first new program. For new programs started on or after October 1, 2012, effective beginning with the facility’s cost reporting period that coincides with or follows the start of the sixth program year of the first new program started, enter the lower of the FTE count on line 7 or the FTE count on line 6. Add to this count the FTEs on line 8 if your fiscal year end does not correspond with the program year end, and this cost reporting period includes the beginning of the sixth program year following the new program growth period of the first new program.

Beginning with the program year that does not coincide with but follows the new program growth period of the first new program’s existence, enter the lower of the FTE count on line 7 or the FTE count on line 6.

Line 10--Enter the total IRF patient days divided by the number of days in the cost reporting period (Worksheet S-3, column 8, line 1 (independent/freestanding), or 17, and applicable subscripts (subprovider/provider based), divided by the total number of days in cost reporting period). This is the average daily census.

**NOTE:** For cost reporting periods overlapping October 1, 2013, subscript column 1 (add column 1.01) for lines 11 and 12. For cost reporting periods beginning on or after October 1, 2013, do not script column 1.

Line 11--For cost reporting periods ending prior to October 1, 2013, calculate in column 1, the teaching adjustment factor by adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the teaching adjustment factor. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } .6876 \text{ power} - 1\}$ .

In accordance with the 78 FR 47869 (August 6, 2013), effective for IRF discharges rendered on or after October 1, 2013, the teaching adjustment factor is updated. For cost reporting periods that overlap October 1, 2013, subscript column 1.

To calculate the teaching adjustment factor for discharges prior to October 1, 2013, enter in column 1 the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of .6876 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } .6876 \text{ power} - 1\}$ . To calculate the teaching adjustment factor for discharges on or after October 1, 2013, enter in column 1.01, the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } 1.0163 \text{ power} - 1\}$ . Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013.

To calculate the teaching adjustment factor for cost reporting periods beginning on or after October 1, 2013, enter in column 1, the result of adding 1 to the ratio of line 9 divided by line 10. Raise that result to the power of 1.0163 and then subtract 1 from this amount. This is expressed mathematically as  $\{(1 + (\text{line } 9 / \text{line } 10)) \text{ to the } 1.0163 \text{ power} - 1\}$ .

Line 12--For cost reporting periods ending prior to October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11. For cost reporting periods that overlap October 1, 2013, subscript column 1. Calculate the teaching adjustment for discharges prior to October 1, 2013 in column 1 by multiplying line 1, column 1 by line 11, column 1. Calculate the teaching adjustment for discharges on or after October 1, 2013, in column 1.01 by multiplying line 1, column 1.01 by line 11, column 1.01. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2013. For cost reporting periods beginning on or after October 1, 2013, calculate the teaching adjustment by multiplying line 1, by line 11.

Line 13--Enter the sum of line 1, columns 1 and 1.01; line 3, columns 1 and 1.01; line 4 and line 12, columns 1 and 1.01.

Line 14--Enter the amount of nursing and allied health managed care payments, if applicable. Only complete this line if your facility is a freestanding/independent non-IPPS hospital that does not complete Worksheet E, Part A.

Line 15--DO NOT USE THIS LINE.

Line 16--Teaching IRFs or IRF subproviders participating in an approved GME program, electing to be reimbursed for services of physicians on the basis of reasonable cost (see 42 CFR 415.160 and CMS Pub. 15-1, chapter 21, §2148), enter the cost of physicians. For cost reporting periods ending before June 30, 2014, transfer the amount from Worksheet D-5, Part II, column 3, line 20. For cost reporting periods ending on or after June 30, 2014, transfer the amount from Worksheet D-5, Part IV, line 20.

Line 17--Enter the sum of lines 13, 14, 15, and 16.

Line 18--Enter the amounts paid or payable by workers' compensation and other primary payers when program liability is secondary to that of the primary payer. There are six situations under which Medicare payment is secondary to a primary payer:

- Workers' compensation,
- No fault coverage,
- General liability coverage,
- Working aged provisions,
- Disability provisions, and
- Working ESRD provisions.

Generally, when payment by the primary payer satisfies the total liability of the program beneficiary, for cost reporting purposes only, the services are treated as if they were non-program services. (The primary payment satisfies the beneficiary's liability when you accept that payment as payment in full. This is noted on no-pay bills submitted in these situations.) Include the patient days and charges in total patient days and charges but do not include them in program patient days and charges. In this situation, enter no primary payer payment on line 18. In addition, exclude amounts paid by other primary payers for outpatient dialysis services reimbursed under the composite rate system.

However, when the payment by the primary payer does not satisfy the beneficiary's obligation, the program pays the lesser of (a) the amount it otherwise pays (without regard to the primary payer payment or deductible and coinsurance) less the primary payer payment, or (b) the amount it otherwise pays (without regard to primary payer payment or deductibles and coinsurance) less applicable deductible and coinsurance. Primary payer payment is credited toward the beneficiary's deductible and coinsurance obligation.

When the primary payment does not satisfy the beneficiary's liability, include the covered days and charges in program days and charges, and include the total days and charges in total days and charges for cost apportionment purposes. Enter the primary payer payment on line 18 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance.

Do not enter on line 18 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 19--Enter line 17 minus line 18.

Line 20--Enter the Part A deductibles.

Line 21--Enter line 19 less line 20.

Line 22--Enter the Part A coinsurance.

Line 23--Enter the result of subtracting line 22 from line 21.

Line 24--Enter program allowable bad debts reduced by recoveries. If recoveries exceed the current year's bad debts, lines 24 and 25 will be negative. (See CMS Pub. 15-1, chapter 3).

Line 25--Multiply the amount (including negative amounts) from line 24 by 70 percent for cost reporting periods beginning prior to October 1, 2012, and 65 percent for cost reporting periods that begin on or after October 1, 2012.

Line 26--Enter the gross allowable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 24.

Line 27--Enter the sum of lines 23 and 25.

Line 28--Enter the amount from Worksheet E-4, line 49 for the hospital component (freestanding IRF) only. Do not complete this line for an IRF unit.

Line 29--Enter the routine service other pass through costs from Worksheet D, Part III, column 9, line 30 for a freestanding facility or line 41 for IRF the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 11, line 200.

Line 30--Enter the outlier reconciliation amount by entering the sum of lines 51 and 53.

Line 31--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, etc., enter the adjustment. (See CMS Pub. 15-1, chapter 21, §2146.4.) Specify the adjustment in the space provided.

Enter on line 31.99 the program share of any recovery of accelerated depreciation applicable to prior periods resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-1, chapter 1, §§136 - 136.16 and 42 CFR 413.134(d)(3)(i).) Identify this line as "Recovery of Accelerated Depreciation."

Line 31.50--Enter the Pioneer ACO demonstration payment adjustment amount. Obtain this amount from the PS&R. Do not use this line for services rendered on or after January 1, 2017. Report any ACO demonstration payment adjustments for services on or after January 1, 2017, on line 31.99 or line 32.02, accordingly.

Line 31.99--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 32--Enter the sum of lines 27, 28, and 29 plus or minus lines 30, and 31, and minus lines 31.50 and 31.99.

Line 32.01--For cost reporting periods that overlap or begin on or after April 1, 2013, enter the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period beginning on or after April 1, 2013, divided by total days in the entire cost reporting period, rounded to four decimal places)) times line 32]. Do not apply the sequestration calculation when gross reimbursement (line 32) is less than zero.

Line 32.02--Enter any demonstration payment adjustment amounts for demonstration projects in which the provider participated where the demonstration adjustment amounts are not subject to the sequestration adjustment. Obtain this amount from the PS&R.

Line 33--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For contractor final settlements, report on line 34 the amount on line 5.99.

Line 35--Enter line 32 minus the sum of lines 32.01, 32.02, 33 and 34. Transfer this amount to Worksheet S, Part III, line 1 or 3, as appropriate.

Line 36--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying a reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See CMS Pub. 15-2, chapter 1, §115.2.) Attach a schedule showing the details and computations.

**DO NOT COMPLETE THE REMAINDER OF WORKSHEET E-3, PART III. LINES 50 THROUGH 53 ARE FOR CONTRACTOR USE ONLY.**

Line 50--Enter the original outlier amount from Worksheet E-3, Part III, line 4.

Line 51--Enter the outlier reconciliation adjustment amount in accordance with CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10.

Line 52--Enter the interest rate used to calculate the time value of money. (See CMS Pub. 100-04, chapter 3, §140.2.8 - §140.2.10)

Line 53--Enter the time value of money.