4033.5 Part V - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement.--Use Worksheet E-3, Part V, to calculate reimbursement settlement for Medicare Part A services furnished under cost reimbursement for (1) CAHs, including those participating in the PARHM demonstration; and (2) new children's or new cancer hospitals exempt from the rate of increase limits in accordance with 42 CFR 413.40(f).

For hospitals participating in the PARHM demonstration during this cost reporting period and (1) the hospital participated in the PARHM demonstration for the entire cost reporting period, select the "PARHM Demonstration" box only and complete this worksheet; or (2) the hospital participated in the PARHM demonstration for a portion of the cost reporting period, select the "PARHM Demonstration" box and complete Worksheet E-3, Part V, for the portion of the cost reporting period included in the demonstration. Select the "Hospital" box and complete a separate Worksheet E-3, Part V, for the portion of the cost reporting period not included in the demonstration.

Line Descriptions

Line 1--Enter the inpatient operating costs for the hospital (CAH, new children's hospital, or new cancer hospital) from Worksheet D-1, Part II, line 49.

Line 2--Enter the amount of nursing and allied health managed care payments, if applicable. Only complete this line if your facility is a CAH.

Line 3--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-4, Part III, column 1, line 69, when this worksheet is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 3 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3.01--Transfer the Medicare inpatient cellular therapy acquisition cost from Worksheet D-6, Part III, line 10, column 1.

Line 4--Enter the sum of lines 1 through 3.01.

Line 5--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 not in program patient days and charges. In this situation, enter no primary payer payment on line 5. 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 5 to the extent that primary payer payment is not credited toward the beneficiary's deductible and coinsurance. Do not enter on line 5 primary payer payments credited toward the beneficiary's deductible and coinsurance.

Line 6--For a new children's or new cancer hospital that is cost reimbursed, enter the result of line 4 minus line 5.

For CAHs: For cost reporting periods beginning before October 1, 2014, if Worksheet S-2, line 167, is "Y", then multiply the amount on line 4 by 101 percent minus the amount on line 5.

For cost reporting periods beginning in FFY 2015 and subsequent years, if the CAH is a meaningful user (Worksheet S-2, line 167, is "Y"), then multiply the amount on line 4 by 101 percent minus the amount on line 5.

If the CAH is not a meaningful user of EHR for cost reporting periods beginning in FFY 2015 and subsequent years, (Worksheet S-2, line 167, is "N") and it does not qualify for a hardship exception (Worksheet S-2, line 168.01, is "N"), calculate line 6 as follows:

For cost reporting periods beginning in FFY 2015 (October 1, 2014, through September 30, 2015), (multiply the amount on line 4 by 100.66 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2016 (October 1, 2015, through September 30, 2016), (multiply the amount on line 4 by 100.33 percent) minus the amount on line 5.
For cost reporting periods beginning in FFY 2017 and each subsequent fiscal year (cost reporting periods beginning on or after October 1, 2016), (multiply the amount on line 4 by 100 percent) minus the amount on line 5.

Computation of Lesser of Reasonable Cost or Customary Charges-- This part provides for the computation of the lesser of reasonable cost of services furnished to beneficiaries or customary charges made by you for the same services, as defined in 42 CFR 413.13(a). A new children's or new cancer hospital exempt from the rate of increase limits must complete lines 7 through 16.

CAHs do not complete lines 7 through 16 as they are exempt from the application of the LCC principle.

Line Descriptions

Lines 7 through 16--These lines provide for the accumulation of charges which relate to the reasonable cost on line 6.

Do not include on these lines (1) the portion of charges applicable to the excess cost of luxury items or services (see CMS Pub. 15-1, chapter 21, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-1, chapter 25, §§2570-2577.

Line 7--Enter the program inpatient routine service charges from your records for the applicable component. Include charges for both routine and special care units. The amounts entered include covered late charges billed to the program when the patient's medical condition is the cause of the stay past the checkout time. Also, these amounts include charges relating to a stay in an intensive care type hospital unit for a few hours when your normal practice is to bill for the partial stay.

Line 8--Enter the total charges for inpatient ancillary services from Worksheet D-3, column 2, sum of lines 50 through 98.

Line 9--If you are an approved CTC, enter the organ acquisition charges from Worksheet D-4, Part III, column 3, line 69, when Worksheet E-3, Part V, is completed for the hospital or the hospital component of a health care complex.

Line 10--Enter the sum of lines 7 through 9.

Lines 11 through 14--These lines provide for the reduction of program charges when you do not actually impose such charges on most of the patients liable for payment for services on a charge basis or when you fail to make reasonable efforts to collect such charges from those patients. If line 13 is greater than zero, multiply line 10 by line 13, and enter the result on line 14. If you impose these charges and make reasonable efforts to collect the charges from patients liable for payment for services on a charge basis, you are not required to complete lines 11 through 13. Enter on line 14 the amount from line 10. In no instance may the customary charges on line 14 exceed the actual charges on line 10. (See 42 CFR 413.13(e).)

Line 15--Enter the excess of the customary charges on line 14 over the reasonable cost on line 6.

Line 16--Enter the excess of reasonable cost on line 6 over the customary charges on line 14. Transfer line 16 to line 21.

Line 17--Teaching hospitals 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. CAHs do not complete this line.

Computation of Reimbursement Settlement

Line 18--New children's or new cancer hospitals enter the amount from Worksheet E-4, line 49. CAHs do not complete this line.

Line 19--Enter the sum of lines 6 and 17.

Line 20--Enter the Part A deductibles billed to Medicare beneficiaries.

Line 21-- Enter the amount from line 16. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 minus lines 20 and 21.

Line 23--Enter from PS&R or your records the coinsurance billed to Medicare beneficiaries.

Line 24--Enter line 22 minus line 23.

Line 25--Enter from your records program allowable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 26 will be negative. (See 42 CFR 413.89.)

Line 26--No reduction is required for CAHs for cost reporting periods beginning prior to October 1, 2012, enter the amount from line 25.

Multiply the amount from line 25 (including negative amounts) by 88 percent for cost reporting periods beginning on or after October 1, 2012, 76 percent for cost reporting periods beginning on or after October 1, 2013, and 65 percent for cost reporting periods beginning on or after October 1, 2014.

Line 27--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 25.

Line 28--Enter the sum of lines 24 and 26.

Line 29--Enter any other adjustments. See line 29.98 to report the recovery of accelerated depreciation.

Line 29.50--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 29.99 or line 30.02, accordingly.

Line 29.98--Enter 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 through 136.16 and 42 CFR 413.134(d)(3)(i).) This line is identified as "Recovery of accelerated depreciation."

Line 29.99--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 30--Enter line 28, plus or minus line 29, and minus lines 29.50, 29.98, and 29.99.

Line 30.01--For cost reporting periods that overlap or begin on or after April 1, 2013, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 30]. Do not apply the sequestration calculation when gross reimbursement (line 30) is less than zero. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times line 30]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times line 30].

Line 30.02--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 30.03--This line is a subset of line 30.01. Calculate the sequestration adjustment amount for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. Calculate the sequestration adjustment amount as [(2 percent times (total days in the cost reporting period that occur during the sequestration period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of lines 2, 3, 18, and 26]. In accordance with §3709 of the CARES Act, as amended by §102 of the CAA 2021, §1 of Public Law 117-7, and §2 of the PAMA 2021, do not apply the sequestration adjustment to the period of May 1, 2020, through March 31, 2022. In accordance with §2 of the PAMA 2021, for cost reporting periods that overlap or begin on or after April 1, 2022, calculate the sequestration adjustment amount for the period of April 1, 2022, through June 30, 2022, as follows: [(1 percent times (total days in the cost reporting period that occur from April 1, 2022, through June 30, 2022, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places), times the sum of (lines 2, 3, 18, and 26)]; and for cost reporting periods that overlap or begin on or after July 1, 2022, calculate the sequestration adjustment amount as follows: [(2 percent times (total days in the cost reporting period that occur on or after July 1, 2022, through the end of the cost reporting period, divided by total days in the entire cost reporting period, rounded to six decimal places), rounded to four decimal places) times the sum of (lines 2, 3, 18, and 26)].

Line 31--Enter interim payments from Worksheet E-1, column 2, line 4. For contractor final settlement, report on line 32 the amount from line 5.99.

Line 31.01--This line is a subset of line 31. Enter the interim pass-through payments received (or receivable) for the portion of the cost reporting period that the hospital participated in the PARHM demonstration. These payments should include bi-weekly pass through payments as well as any lump sum adjustments received for bad debts, organ acquisition costs, and medical education (DGME and NAHE).

Line 33--Enter line 30 minus the sum of lines 30.01, 30.02, 31, and 32. Transfer this amount to Worksheet S, Part III, columns as appropriate, line 1. For providers participating in the PARHM demonstration, do not transfer amounts from this line. See line 33.01 for instruction.

Line 33.01--For providers participating in the PARHM demonstration, complete this line for the settlement of pass-through payments paid outside of the PARHM demonstration. The amount reported on this line is a subset of the amount reported on line 33. Enter the sum of lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01. Transfer this amount to Worksheet S, Part III, columns as appropriate, line 1.01.

Line 34--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 for this line.

4033.6 Part VI - Calculation of Reimbursement Settlement - Title XVIII Part A PPS SNF Services.--For title XVIII SNFs reimbursed under PPS (including a distinct part SNF based in a REH), complete this part for settlement of Part A services. For Part B services, all SNFs complete Worksheet E, Part B.

When this part is completed for a component, show both the hospital and component numbers.

Computation of Net Costs of Covered Services

Line Descriptions

Prospective Payment Amount

Line 1--Compute the sum of the following amounts obtained your books and records or from the PS&R:

- The Resource Utilization Group (RUG) payments made for PPS discharges during the cost reporting period, and
- The RUG payments made for PPS transfers during the cost reporting period.

Line 2--Enter the amount from Worksheet D, Part III, column 9, line 44.

Line 3--Enter the amount from Worksheet D, Part IV, column 11, line 200.

Line 4--Enter the sum of lines 1 through 3.

Line 5--Do not use this line as vaccine costs are included on line 1 of Worksheet E, Part B. Line 5 is shaded on Worksheet E-3, Part VI.

Line 6--Enter any deductible amounts imposed.

Line 7--Enter any coinsurance amounts.

Line 8--Enter from your records program allowable bad debts for deductibles and coinsurance net of bad debt recoveries. If recoveries exceed the current year's bad debts, line 8 will be negative. (See 42 CFR 413.89.)