3633. WORKSHEET E-3 - CALCULATION OF REIMBURSEMENT SETTLEMENT

The five parts of Worksheet E-3 are used to calculate reimbursement settlement:

- Part I- Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS
- Part II- Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement *(CAHs)*
- Part III- Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services - Part A Services for Title XVIII PPS SNFs
- Part IV- Direct Graduate Medical Education and ESRD Outpatient Direct Medical Education Costs
- Part V- Calculation of NHCMQ Demonstration Reimbursement Settlement for Medicare Part A Services

3633.1 Part I - Calculation of Medicare Reimbursement Settlement Under TEFRA, IRF PPS, LTCH PPS, and IPF PPS.--Use Worksheet E-3, Part I to calculate Medicare reimbursement settlement under TEFRA for hospitals and subproviders.

Use a separate copy of Worksheet E-3, Part I for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3, Part I 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

Lines 1.01, 1.02, 1.05, and 1.06 pertain only to inpatient rehabilitation facilities (IRF) for cost reporting periods beginning on or after January 1, 2002 and long term care hospitals (LTCH) for cost reporting periods beginning on or after October 1, 2002. Line 1.03 and 1.04 pertain only to IRFs with cost reporting periods beginning on or after January 1, 2002. (See §1886(j) of the Act and PMs A-01-110 and A-01-131). Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005. Lines 1.08 through 1.23 are used exclusively for IPF services. (See Vol. 69, FR 219 dated November 15, 2004, page 66922 and CRs 3541 (December 1, 2004), 3678 (January 21, 2005), 3752 (March 4, 2005), and 3809 (April 29, 2005))

Line 1--Enter (for TEFRA hospitals, IRFs, and subprovider) the amount from Worksheet D-1, Part II, line 59. For IRFs, if Worksheet S-2, line 58, column 2 is yes, or for cost reporting period beginning on or after October 1, 2002, enter zero on this line. Enter for LTCHs with cost reporting periods beginning on or after October 1, 2002 and before October 1, 2006 the amount from Worksheet D-1, Part II, line 59.08. For LTCHs, if Worksheet S-2, line 59, column 2 is yes, or for cost reporting period beginning on or after October 1, 2006, enter zero on this line. Enter for IPFs with cost reporting periods beginning on or after January 1, 2005 and before January 1, 2008 the amount from Worksheet D-1, Part II, line 59. For IPFs, if Worksheet S-2, line 60, column 2 is yes, or for cost reporting period beginning on or after January 1, 2008, enter zero on this line.

Line 1.01--For IRFs enter hospital specific amount by multiplying line 1 times 33 1/3 percent. For LTCH enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (see 42 CFR §412.533(a)(1)) for the appropriate cost reporting period. For IPF enter the hospital specific amount by multiplying line 1 times the blended TEFRA rate percentage (See 42 CFR §412.426(a)) for the appropriate cost reporting period.

Line 1.02--Enter the Net Federal IRF PPS for cost reporting periods beginning on or after January 1, 2002. 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. If line 1.01 is greater than zero, the PS&R will reflect 66 2/3 percent of the Federal IRF PPS payment amount (excluding LIP and outlier payments).

In accordance with The Federal Register, Vol. 70 FR 156 page 47933, dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for IRF discharges rendered on or after October 1, 2005, it is necessary to subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2005 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2005 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2005, *except as otherwise indicated in the following paragraph.* Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise indicated in the following paragraph.*

In accordance with the Federal Register, volume. 74, number 151, page 39774, dated August 7, 2009, effective for IRF discharges rendered on or after October 1, 2009, subscript column 1 to identify the Net Federal IRF PPS payments associated with IRF PPS discharges prior to October 1, 2009 (column 1) and the Net Federal IRF PPS payments associated with IRF PPS discharges on or after October 1, 2009 (column 1.01) to appropriately prorate the LIP adjustment on line 1.04. Only subscript column 1 when the cost reporting period overlaps October 1, 2009. Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2009.

Enter the Net Federal LTCH PPS payment for cost reporting periods beginning on or after October 1, 2002, including short stay outlier payments. Obtain this information from the PS&R and/or your records. If line 1.01 is greater than zero, the PS&R will reflect the applicable reduced percent of the Federal IRF PPS payment amount (excluding short stay outlier payments). (See Vol. 67 FR 169 dated August 30, 2002, page 55976 for rates.)

Line 1.03--Enter the Medicare SSI ratio from your intermediary as applicable for a freestanding IRF (IRF hospital or facility) or a hospital based IRF (subprovider or subunit). Not applicable for LTCH. (4/30/2003)

Line 1.04--IRF LIP payment, enter the result of {(1 + (line 1.03) +(L2/L3)) to the .4838 power - 1} times (line 1.02). L1 = IRF total Medicare Days from Worksheet S-3, Part I, column 4, lines 1 or 14 and subscripts as applicable (L1 is not applicable for T10 & subsequent transmittals). L2 = IRF Medicaid Days from Worksheet S-3, Part I, column 5, lines 1 or 14 and subscripts as applicable plus Medicaid HMO days (S-3, Part I, column 5, line 2 (subscript line 2 for IRF subproviders)). L3 = IRF total days from Worksheet S-3, Part I, column 6, lines 1 or 14 and subscripts as applicable plus employee discount days (S-3, Part I, column 6, line 28 (subscript line 28 for IRF subproviders)). Not applicable for LTCH.

In accordance with Vol. 70 FR 156 page 47933 dated August 15, 2005 and CR 4037 dated September 16, 2005, effective for discharges on or after October 1, 2005, the IRF LIP payment formula has been updated. For cost reporting periods that overlap October 1, 2005, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2005, enter in column 1 the result of {(1 + (line 1.03) + (L2/L3)) to the .4838 power - 1} times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2005, enter in column 1.01 the result of {(1 + (line 1.03) +(L2/L3)) to the .6229 power - 1} times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after October 1, 2005, *except as otherwise noted.* To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2005, enter in column 1 the result of {(1 + (line 1.03) +(L2/L3)) to the .6229 power - 1} times line 1.02. Not applicable for LTCH.

In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the IRF LIP payment formula is updated. For cost reporting periods that overlap October 1, 2009, column 1 must be subscripted. To calculate the IRF LIP payment for discharges prior to October 1, 2009, enter in column 1 the result of {(1 + (line 1.03) + (L2/L3)) to the .6229 power - 1} times (line 1.02, column 1). To calculate the IRF LIP payment for discharges on or after October 1, 2009, enter in column 1.01 the result of {(1 + (line 1.03) +(L2/L3)) to the .4613 power - 1} times (line 1.02, column 1.01). Do not subscript column 1 for cost reporting periods beginning on or after

October 1, 2009. To calculate the IRF LIP payment for cost reporting periods beginning on or after October 1, 2009, enter in column 1 the result of {(1 + (line 1.03) +(L2/L3)) to the .4613 power - 1} times line 1.02. Not applicable for LTCH.

Line 1.05--Enter the IRF outlier payment. For LTCH enter the high cost outlier payments. Obtain this from the PS&R and/or your records.

Line 1.06--Enter the sum of lines 1.01; 1.02, columns 1 and 1.01, as applicable; 1.04, columns 1 and 1.01, as applicable*; 1.42, columns 1 and 1.01 as applicable,* and 1.05.

Line 1.07--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-PPS provider that does not complete Worksheet E, Part A.

Inpatient psychiatric facilities (IPF) complete lines 1, 1.01 and 1.08 through 1.23 for cost reporting periods beginning on or after January 1, 2005.

Inpatient Psychiatric Facility (IPF)-Lines 1.08 through 1.23
In accordance with the Federal Register (see Vol. 69, FR 219 dated November 15, 2004, page 66922) and Change Request 3541 (CMS Pub. 100-04, transmittal 384 dated December 1, 2004) and Change Request 3678 (CMS Pub. 100-04, transmittal 444 dated, January 21, 2005) complete these lines for IPFs effective for cost reporting periods beginning on or after January 1, 2005.

Line 1.08--Enter the net (blended) Federal IPF PPS payment for cost reporting periods beginning on or after January 1, 2005. This amount excludes payments for outliers, stop-loss, electroconvulsive therapy (ECT), and the teaching adjustment. Obtain this information from the PS&R and/or your records.

Line 1.09--Enter the net (blended) IPF outlier payment. Obtain this from the PS&R and/or your records.

Line 1.10--Enter the net (blended) IPF payments for ECT. Obtain this from the PS&R and/or your accounting books and records.

NOTE: Complete only line 1.11 or line 1.12, but not both.

Line 1.11--For providers that trained residents **in the most recent cost reporting period filed before November 15, 2004** (response on Worksheet S-2, line 60.01, column 1 is "Y" for yes), enter the unweighted FTE resident count for the most recent cost reporting period filed on or before November 15, 2004. See the above referenced Federal Register for a detailed explanation.

Line 1.12--For providers that did not train residents in the most recent cost reporting period filed before November 15, 2004, but qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to Worksheet S-2, line 60.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.13--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.14--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.15--For providers that completed line 1.11, enter the lower of the FTE count on line 1.13 or the cap amount on line 1.11.

For providers that qualify to receive a cap adjustment under §412.424(d)(1)(iii)(2) during the first 3 program years of the first new program's existence, enter the FTE count from line 1.14.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 1.13 or the FTE count on line 1.12. Add to this count the FTEs on line 1.14 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4th program year of the first new program.

Line 1.16--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.17--Enter the medical education adjustment factor by adding 1 to the ratio of line 1.15 to line 1.16. Raise that result to the power of .5150. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 1.15 / line 1.16)) to the .5150 power - 1}.

Line 1.18--Enter the medical education adjustment by multiplying line 1.08 by line 1.17.

Line 1.19--Enter the adjusted net IPF PPS payments by entering the sum of lines 1.08, 1.09, 1.10, and 1.18.

Line 1.20--Enter the stop loss floor by entering the result of line 1 multiplied by 70 percent. For new IPFs (100 percent PPS) and for cost reporting periods beginning on or after January 1, 2008, enter zero (0) on this line.

Line 1.21--Enter the adjusted net payment floor by multiplying line 1.20 by the appropriate Federal blend payment percentage: (25 percent for cost reporting periods beginning on or after January 1, 2005 but prior to January 1, 2006, 50 percent for cost reporting periods beginning on or after January 1, 2006 but prior to January 1, 2007, or 75 percent for cost reporting periods beginning on or after January 1, 2007 but prior to January 1, 2008). Enter 100 percent if this is a new IPF (worksheet S-2, line 60, column 2 equals "Y") or for cost reporting periods beginning on or after January 1, 2008.

Line 1.22--If line 1.21 is greater than line 1.19 enter the amount on line 1.21 minus the amount on line 1.19; otherwise enter zero (0). This is the amount of the stop loss adjustment.

Line 1.23--Enter the IPF PPS payments by adding the amounts from lines 1.01, 1.19 and 1.22.

Inpatient Rehabilitation Facility (IRF)-Lines 1.35 through 1.42

In accordance with the Federal Register (see Vol. 70, No. 156, pages 47928-47932, dated August 15, 2005) and Change Request 4037 (CMS Pub. 100-04, transmittal 680 dated September 16, 2005),complete these lines for IRFs effective for discharges on or after October 1, 2005.

NOTE: Complete only line 1.35 or line 1.36, but not both.

Line 1.35--For providers that trained residents **in the most recent cost reporting period ending on or before November 15, 2004** (response to line 58.01, 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. See the above referenced Federal Register for a detailed explanation.

Line 1.36--For providers that did not train residents in the most recent cost reporting period ending on or before November 15, 2004, that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005) for training residents in a newly accredited program(s) after that cost reporting period, enter the unweighted cap adjustment (response to line 58.01, column 2 is "Y" for yes and column 3 contains a "4" or "5"). Do not complete this line until the fourth program year of the first new program. If your fiscal year end does not correspond to the program year end, and this current cost reporting period includes the beginning of the fourth program year of the first new program, then prorate the cap adjustment accordingly.

Line 1.37--Enter the current year unweighted FTE resident count for **other than the FTEs** in the first 3 program years of the first new program's existence. If your fiscal year end does not correspond to the program year end and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.38--Enter the current year unweighted FTE count for residents in new programs. Complete this line only during the first 3 program years of the first new program's existence. If your fiscal year end does not correspond with the program year end, and the current cost reporting period includes the beginning of the 4th program year of the first new program, then prorate the count accordingly.

Line 1.39--For providers that completed line 1.35, enter the lower of the FTE count on line 1.37 or the cap amount on line 1.35.

For providers that qualify to receive a cap adjustment (see Vol. 70, FR 156, page 47929, dated August 15, 2005), during the first 3 program years of the first new program's existence enter the FTE count from line 1.38.

Beginning with the 4th program year of the first new program's existence, enter the lower of the FTE count on line 1.37 or the FTE count on line 1.36. Add to this count the FTEs on line 1.38 if your fiscal year end does not correspond with the teaching program year end, and this current cost reporting period includes the beginning of the 4th program year of the first new program.

Line 1.40--Enter the total IPF patient days divided by number of days in the cost reporting period (Worksheet S-3, column 6, line 1 (independent/freestanding) or 14 and applicable subscripts (subprovider/provider based) divided by the total number of days in cost reporting period). This is the average daily census.

Line 1.41--*For discharges prior to October 1, 2009, enter in column 1* the medical education adjustment factor by adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 1.39 / line 1.40)) to the .9012 power - 1}.

In accordance with the Federal Register, volume 74, number 151, date August 7, 2009, page 39774, effective for discharges on or after October 1, 2009, the medical education adjustment factor has been updated making it necessary to subscript column 1 for lines 1.41 and 1.42 for cost reporting periods that overlap October 1, 2009.

Calculate the medical education adjustment factor for discharges prior to October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .9012. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 1.39 / line 1.40)) to the .9012

power - 1}. To calculate the medical education adjustment factor for discharges on or after October 1, 2009, enter in column 1.01 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 1.39 / line 1.40)) to the .6876 power - 1}. Do not subscript column 1 for lines 1.41 and 1.42 for cost reporting periods beginning on or after October 1, 2009.

Calculate the medical education adjustment factor for cost reporting periods beginning on or after October 1, 2009, by entering in column 1 the result of adding 1 to the ratio of line 1.39 to line 1.40. Raise that result to the power of .6876. Subtract 1 from this amount to calculate the medical education adjustment factor. This is expressed mathematically as {(1 + (line 1.39 / line 1.40)) to the .6876 power - 1}.

Line 1.42--Enter in *column 1*, the medical education adjustment by multiplying line 1.02, *column 1* by line 1.41, *column 1*. *If applicable, enter in column 1.01, the medical education adjustment by multiplying line 1.02, column 1.01 by line 1.41, column 1.01.* Add the *amounts in columns 1 and 1.01* to line 1.06.

Line 2--If you are an approved CTC, enter the cost of organ acquisition from Worksheet(s) D-6, Part III, column 1, line 61 when Worksheet E-3, Part I, is completed for the hospital (or the hospital component of a health care complex). Make no entry on line 2 in other situations because the Medicare program reimburses only CTCs for organ acquisition costs.

Line 3--For hospitals or subproviders that have elected to be reimbursed for the services of teaching physicians on the basis of cost, enter the amount from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1, 1.07, 2 and 3. IRFs/LTCH enter the sum of lines 1.06, 1.07, 2 and 3. IPFs enter the sum of lines 1.23, 2, and 3.

Line 5--Enter the amounts paid or payable by workmens' 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:

- Workmen's' 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 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--Enter line 4 minus line 5.

Line 7--Enter the Part A deductibles.

Line 8--Enter line 6 less line 7.

Line 9--Enter the Part A coinsurance. Include any primary payer amounts applied to Medicare beneficiaries coinsurance in situations where the primary payer payment does not fully satisfy the obligation of the beneficiary to the provider. Do not include any primary payer payments applied to Medicare beneficiary coinsurance in situations where the primary payer payment fully satisfies the obligation of the beneficiary to the provider.

Line 10--Enter the result of subtracting line 9 from line 8.

Line 11--Enter program reimbursable bad debts reduced by recoveries. If recoveries exceed the current year’s bad debts, lines 11 and 11.01 will be negative.

Line 11.01--Multiply the amount (including negative amounts) from Line 11 by 100 percent for cost reporting periods beginning on or after October 1, 1996; 75 percent for October 1, 1997; 60 percent for October 1, 1998; 55 percent for October 1, 1999; and 70 percent for October 1, 2000 and all subsequent periods.

Line 11.02--Enter the gross reimbursable bad debts for dual eligible beneficiaries. This amount is reported for statistical purposes only. This amount must also be reported on line 11. (4/1/2004b)

Line 12--Enter the sum of lines 10 and 11.01.

Line 13--Enter the amount from Worksheet E-3, Part IV, line 24 for the hospital component only.

Line 13.01--For IRF cost reporting periods beginning on or after January 1, 2002, LTCH cost reporting periods beginning on or after October 1, 2002, and IPF cost reporting periods beginning on or after January 1, 2005, enter the routine service other pass through costs from Worksheet D, Part III, column 8, line 25 for a freestanding facility or line 31 for the subproviders. Add to this amount the ancillary service other pass through costs from Worksheet D, Part IV, column 7, line 101. For IRFs, LTCHs, or IPFs reimbursed on a blended TEFRA rate percentage (worksheet S-2, line 58, 59, or 60, respectively, column 2 equals “N”) reduce the pass through amounts by the TEFRA blend percentage used on line 1.01 for IRFs, IPFs, and LTCHs, respectively. After the respective transition periods have elapsed do not reduce this line as these facilities are entitled to 100 percent of other pass through costs.

Line 14--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from your termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 15--Enter any other adjustments. For example, if you change the recording of vacation pay from the cash basis to accrual basis, sequestration, etc, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided. FIs only complete line 15.99 by entering the sum of lines 51 and 53.

Line 16--Enter the program's share of any net depreciation adjustment applicable to prior years resulting from the gain or loss on the disposition of depreciable assets. (See CMS Pub. 15-I, §§132-132.4.)

Line 17--Enter the sum of lines 12, 13, and 13.01 plus or minus lines 15 and 16 minus line 14.

Line 18--Enter the sequestration adjustment amount, if applicable.

Line 19--Enter the amount of interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlements, report on line 19.01 the amount on line 5.99.

Line 20--Enter line 17 minus the sum of lines 18 and 19. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 21--Enter the program reimbursement effect of protested items. Estimate the reimbursement effect of the nonallowable items by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. (See §115.2.) Attach a schedule showing the details and computations.

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

Line 50--Enter the original outlier amount from worksheet E-3, Part I, line 1.05 (IRF) or 1.09 (IPF).

Line 51--Enter the operating outlier reconciliation amount in accordance with CMS Pub. 100-04, Chapter 3, §20.1.2.5-§20.1.2.7.

Line 52--Enter the interest rate used to calculate the time value of money. (see CMS Pub. 100-04, Chapter 3, §20.1.2.5 - §20.1.2.7.)

Line 53--Enter the time value of money.

NOTE: If a cost report is reopened more than one time, subscript lines 50 through 53, respectively, one time for each time the cost report is reopened.

3633.2 Part II - Calculation of Reimbursement Settlement for Medicare Part A Services - Cost Reimbursement.--Use Worksheet E-3, Part II, to calculate reimbursement settlement for Medicare Part A services furnished by hospitals, including rural primary care hospitals/critical access hospitals, subproviders, and skilled nursing facilities under cost reimbursement (i.e., neither PPS nor TEFRA).

For cost reporting periods beginning on or after July 1, 1998, SNFs will not complete this form. Use a separate copy of Worksheet E-3 for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of Worksheet E-3 to indicate the component program 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 appropriate inpatient operating costs:

Hospital (CAH) or Subprovider - Worksheet D-1, Part II, line 49
Skilled Nursing Facility - Worksheet D-1, Part III, line 82
RPCH - Worksheet C, Part IV, line 6 (Not applicable for cost reporting periods beginning after October 1, 1997)