

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)

Line 1.01--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 or CAH that does not complete Worksheet E, Part A.

Line 2--If you are approved as a CTC, enter the cost of organ acquisition from Worksheet D-6, Part III, column 1, line 61 when this worksheet 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 amounts from Worksheet D-9, Part II, column 3, line 16.

Line 4--Enter the sum of lines 1 through 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:

- Workmens' 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--Enter the amount on line 4 minus the amount on line 5. For CAHs with cost reporting periods beginning on or after January 1, 2004, enter on this line 101 percent of the line 4 minus line 5. (1/1/20004b)

Computation of Lesser of Reasonable Cost or Customary Charges.--You are paid the lesser of the reasonable cost of services furnished to beneficiaries or the customary charges made by you for the same services. This part provides for the computation of the lesser of reasonable cost as defined in 42 CFR 413.13(d) or customary charges as defined in 42 CFR 413.13(e). An RPCH/CAH is not subject to this provision for inpatient services.

Line Descriptions

NOTE: An RPCH/CAH does not complete lines 7 through 17.

Lines 7 through 17--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-I, §2104.3) and (2) your charges to beneficiaries for excess costs as described in CMS Pub. 15-I, §§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-4, column 2, sum of lines 37 through 68.

NOTE: If the amounts on Worksheet D-4 include charges for professional services, eliminate the amount of the professional component from the charges entered on line 11. Submit a schedule showing these computations with the cost report.

Line 9--When Worksheet E-3 is completed for a CTC hospital component, enter the organ acquisition charges from Worksheet D-6, Part III, line 61, column 3.

Line 10--Enter your charges for the services for which the cost is entered on line 3.

Line 11--Enter the sum of lines 7 through 10.

Lines 12 through 15--These lines provide for the reduction of program charges when you do not actually impose such charges (in the case of most 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 14 is greater than zero, multiply line 11 by line 14, and enter the result on line 15. 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 12 through 14. Enter on line 15 the amount from line 11. In no instance may the customary charges on line 15 exceed the actual charges on line 11. (See 42 CFR 413.13(e).)

Line 16--Enter the excess of the customary charges on line 15 over the reasonable cost on line 6.

Line 17--Enter the excess of reasonable cost on line 6 over the customary charges on line 15. Transfer line 17 to line 21.

Computation of Reimbursement Settlement

Line 18--Enter the amount from Worksheet E-3, Part IV, line 24. Complete for the hospital component only.

Line 19--Enter the sum of lines 6 and 18.

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

Line 21--Enter the amount, if any, recorded on line 17. If you are a nominal charge provider, enter zero.

Line 22--Enter line 19 less the sum of 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 reimbursable bad debts net of recoveries. If recoveries exceed the current year's bad debts, lines 25 and 25.01 will be negative.

Line 25.01--Multiply the amount (including negative amounts) on Line 25 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 and 55 percent for October 1, 1999; 70 percent for October 1, 2000 and all subsequent periods. No reduction is required for critical access hospitals.

Line 25.02--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 25. (4/1/2004b)

Line 26--Enter the sum of lines 24 and 25 or 25.01 (hospitals and subproviders only).

Line 27--Enter the program's share of any recovery of excess depreciation applicable to prior years resulting from provider termination or a decrease in Medicare utilization. (See CMS Pub. 15-I, §§136-136.16.)

Line 28--Enter any other adjustments. For example, if you change the recording of vacation pay from cash basis to accrual basis, enter the adjustment. (See CMS Pub. 15-I, §2146.4.) Specify the adjustment in the space provided.

For SNFs only, include the title XVIII portion of the amount of the State's bill for determining the validity of nurse aide training and testing under §4211(b)(5) of P.L. 100-203. This adjustment includes the State's cost of deeming individuals to have completed training and testing requirements and the State's cost of determining the competency of individuals trained by or in a facility based program.

Line 29--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 30--Enter line 26, plus or minus lines 28 and 29, minus line 27.

Line 31--Enter the sequestration adjustment amount, if applicable.

Line 32--Enter interim payments from Worksheet E-1, column 2, line 4. For intermediary final settlement, report on line 32.01 the amount from line 5.99.

Line 33--Enter line 30 minus the sum of lines 31 and 32. Transfer this amount to Worksheet S, Part II, line as appropriate.

Line 34--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 for this line.

3633.3 Part III - Calculation of Reimbursement Settlement - All Other Health Services for Titles V or XIX Services and Part A Services for Title XVIII PPS SNFs.--Worksheet E-3 calculates reimbursement for titles V or XIX services for hospitals, subproviders, other nursing facilities and ICF/MRs. For titles V and XIX, complete column 1. For title XVIII SNFs reimbursed under PPS, complete this part for settlement of Part A services using column 2. For Part B services, all SNFs complete Worksheet E, Part B.

Use a separate copy of this part for each of these reporting situations. Enter check marks in the appropriate spaces at the top of each page of this part to indicate the component and program for which it is used. When this part is completed for a component, show both the hospital and component numbers. Enter check marks in the appropriate spaces to indicate the applicable reimbursement method for inpatient services (e.g., PPS, TEFRA, OTHER).

If the State program is under PPS for inpatient hospital services, do not complete line 1. Complete lines 24 through 32 for services covered by PPS. Complete lines 2 through 8, 9 through 15, and 16 through 23 only for services not covered by PPS. If the State program follows TEFRA for inpatient hospital services, do not complete lines 24 through 29. If the State program follows cost reimbursement, do not complete lines 15 and 24 through 29.