Small Rural Hospital Transition (SRHT) Project Guide

Understanding the Hospital Medicare Cost Report Uncompensated and Indigent Care Data Form CMS-2552-10 (Worksheet S-10)

September 22, 2015

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This is a publication of the Technical Assistance and Services Center (TASC), a program of the National Rural Health Resource Center. This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UB1RH24206, Information Services to Rural Hospital Flexibility Program Grantees, $1,191,507 (0% financed with nongovernmental sources). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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PREFACE

This guide is developed to provide rural hospital executive and management teams with a greater understanding of Worksheet S-10. It is also designed to assist State Offices of Rural Health directors and Flex Program coordinators in gaining a better understanding so that they may develop educational trainings to further assist rural hospitals with preparation and utilization of Worksheet S-10.

The information presented in this guide is intended to provide the reader with guidance on completing Worksheet S-10 in accordance with Form CMS-2552-10 (Hospital Cost Report) instructions as they currently exist. The materials do not constitute, and should not be treated as professional advice regarding compliance with Medicare laws or regulations. Cost reports are subject to review by Medicare Administrative Contractors and others with oversight responsibility. Professional judgment is used in resolving questions where the cost report and reimbursement rules and regulations are unclear. Reviewers may choose to interpret rules and regulations in a manner different than that reflected in this guide. Every effort has been made to assure the accuracy of these materials. The National Rural Health Resource Center (The Center), Rural Health Innovations (RHI), Draffin & Tucker, LLP and the authors do not assume responsibility for any individual's reliance upon the information provided in this guide. Readers and users should independently verify all statements made before applying them to a particular fact situation, and should independently determine the correctness of any particular directive before recommending it to a hospital or implementing it on the hospital’s behalf.

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INTRODUCTION

Purpose of this Guide

This guide has been developed to assist rural hospitals with completing the Centers for Medicare and Medicaid Services' (CMS) Worksheet S-10 in accordance with the Form CMS-2552-10 (Hospital Cost Report) instructions as they currently exist. It is designed to help both critical access hospitals (CAHs) and rural prospective payment system (PPS) hospitals gain a better understanding of the purpose, preparation, and utilization of Worksheet S-10 and the related uncompensated care components. The guide provides rural hospital executive and management teams a practical approach to understanding how the reported data could impact future Medicare uncompensated care payments and how it currently impacts Medicare and Medicaid Electronic Health Record Incentive Payments. Hospital teams will learn what particular information is being requested for each line. The overall purpose of this guide is to help hospital administrators gain a greater understanding of how to accurately complete the worksheet and the potential implications and uses of this data by CMS and other third parties.

What is Worksheet S-10

The Balanced Budget Refinement Act requires short-term acute care hospitals to submit data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. The Centers for Medicare and Medicaid Services (CMS) developed Worksheet S-10 of the Medicare hospital cost report to capture the required data. "Worksheet S-10 data are the only primary national data available for individual hospital uncompensated care amounts."[1]

Hospitals paid under the inpatient prospective payment system (IPPS) and critical access hospitals (CAHs) are required to complete Worksheet S-10. Instructions for

[1] Dobson DaVanzo & Associates, LLC and KNG Health Consulting, LLC; *Improvements to Medicare Disproportionate Share Hospital (DSH) Payments*; HHSM 500-2011-00014I; Task Order: HHSM 500-TO001 April 25, 2013

completing the worksheet are available on CMS's website.[2] A copy of the instructions has been included in Appendix B. Additional cost report guidance is available on Health Financial Systems' website.[3]

In anticipation of Worksheet S-10 being used to shape future health policy and funding decisions, the American Hospital Association convened a workgroup of state association and hospital experts on cost reporting to address issues related to the completion of this worksheet. They submitted a letter to CMS in October 2012 related to their recommendations and requests for clarification.[4] However, CMS has not released additional guidance as of the date of this publication.

Utilization of Worksheet S-10

Disproportionate Share Hospital (DSH) Payment Methodology

The federal fiscal year (FFY) 2014 IPPS final rule implements the Affordable Care Act's changes to the Medicare operating Disproportionate Share Hospital (DSH) payment methodology. These changes are the result of a 2007 Medicare Payment Advisory Commission (MedPAC) report to Congress asserting that DSH payments did not correlate to the amount of uncompensated care hospitals provided.[5] MedPAC recommended updating the Medicare cost report to collect the necessary data and reallocating DSH payments on the basis of each hospital's aggregate costs for uncompensated care.

Following MedPAC's recommendations, CMS redesigned Worksheet S-10 to collect data related to uncompensated care services, but chose not to use its data to allocate uncompensated care payments until "hospitals are submitting accurate and consistent data through this reporting mechanism." CMS intends "to propose

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[2] Centers for Medicare and Medicaid Services; Chapter 40 Hospital & Hospital Health Care (Form CMS-2552-10)

[3] Health Financial Systems FAQ on Form CMS-2552-10 Hospital Medicare Cost Report

[4] American Hospital Association; *AHA requests changes to CMS worksheet for reporting uncompensated care*, October, 2012

[5] Medicare Payment Advisory Commission March 2007 Report to the Congress; Medicare Payment Policy, Section 2A-3

introducing use of the Worksheet S-10 to determine Factor 3 [of the uncompensated care payment formula] within a reasonable amount of time."[6]

Under the old DSH method, hospitals qualified for a DSH payment adjustment under a statutory formula that considers their Medicare utilization of beneficiaries who also receive Supplemental Security Income (SSI) benefits and their Medicaid utilization. Beginning with discharges occurring on or after October 1, 2013, operating DSH has been split into two separate payments: 25% based on the old payment methodology (now called "empirically justified Medicare DSH payments") plus an allocation from a new Medicare DSH uncompensated care pool. The pool is equal to 75% of what otherwise would have been paid as Medicare DSH payments after a reduction for changes in the percentage of individuals under the age of 65 who are uninsured. Each hospital qualifying for empirically justified Medicare DSH payments will receive an uncompensated care pool allocation based on its share of the total amount of uncompensated care for all Medicare DSH hospitals.

Electronic Health Record (EHR) Incentive Payments

The Medicare and Medicaid Electronic Health Record (EHR) incentive payment program was established by the American Recovery and Reinvestment Act of 2009.[7] A component of the EHR incentive payment calculation uses data from CMS's Worksheet S-10, line 20, column 3 related to charity care services. EHR incentive payments are available to CAHs through FFY 2015 and IPPS hospitals through FFY 2016. Charity care charges reported on Worksheet S-10 serve to increase the hospital's Medicare and Medicaid share percentages, which result in higher incentive payments.

340B Drug Pricing Program

The Alliance for Integrity and Reform of 340B (AIR 340B) issued a report in spring 2014 titled "Unfulfilled Expectations: An analysis of charity care provided by 340B hospitals."[8] The analysis used Worksheet S-10, line 23 (cost of charity care) to conclude "many hospitals enrolled in the 340B Drug Pricing Program are not fulfilling Congress' expectations. While there are some 340B hospitals that provide considerable charity care, charity care represents 1% or less of patient costs at

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[6] Federal Register, Vol. 78, No. 160, *FFY 2014 IPPS Final Rule*; August 19, 2013

[7] CMS Electronic Health Records Incentive Programs

[8] The Alliance for Integrity and Reform of 340B; *Unfulfilled Expectations: An analysis of charity care provided by 340B hospitals*; 2014

approximately one-quarter of 340B hospitals." The AIR 340B report serves as a reminder of how important accurate cost reporting is considering the reports are open to public scrutiny.

Unreimbursed Costs for Medicaid, SCHIP, and State and Local Indigent Care Programs

Worksheet S-10 calculates the unreimbursed cost/payment shortfalls, if any, of providing services to Medicaid, State Children's Health Insurance Program (SCHIP), and indigent care program patients (Lines 8, 12 and 16, respectively). Refer to Appendix A for examples of a completed Worksheet S-10 with data from actual cost reports filed by hospitals. Please note the completed lines in the examples would not apply to all hospitals.

Cost-to-Charge Ratio on Line 1

Line 1 includes the cost-to-charge ratio (CCR) used to calculate the cost of services reported on Worksheet S-10. This overall CCR is calculated by dividing Worksheet C, Part I, line 202, column 3 by line 202, column 8. The CCR includes all components of the hospital complex (e.g., hospital-based nursing facility or rural health clinic) except physician or other professional services.

Net Revenue on Line 2 (Medicaid), Line 9 (SCHIP) and Line 13 (State or Local Indigent Care Program)

Net revenue is actual payments received or expected to be received, including copayments from the patient, for services delivered during the cost reporting period. Net revenue is typically gross charges less contractual allowances. Payments are included for the entire hospital facility except for physician or other professional services. Cost report settlement amounts should be considered, if applicable.

Line 2 includes payments for Medicaid (Title XIX) covered services where Medicaid is the primary payer. This includes an expansion SCHIP program and Medicaid managed care programs.

Line 9 includes payments for stand-alone SCHIP (Title XXI) covered services, including managed care programs.

Line 13 includes payments for patients covered by a state or local government indigent care program other than Medicaid or SCHIP. These payments are related to specific patient accounts documented through the provider's patient accounting system. Non-patient specific payments are included on line 18.

Charges on Line 6 (Medicaid), Line 10 (SCHIP) and Line 14 (State or Local Indigent Care Program)

Charges on lines 6, 10 and 14 are the gross revenue for services delivered during the cost reporting period that are related to the payments included on lines 2, 9 and 13, respectively. Charges are included for the entire hospital facility except for physician or other professional services. Expected payments on unpaid accounts will need to be estimated for lines 2, 9 and 13.

Medicaid DSH or Supplemental Payments

DSH or supplemental payments received or expected from Medicaid are reported on line 2 if included with patient claims processing. Include all other payments received, not included in line 2, on line 5. Payments should be net of associated provider taxes or assessments.

Non-Governmental Grants, Gifts and Investment Income

Line 17 includes non-patient specific revenue received during the cost reporting period from non-governmental entities that was restricted to funding uncompensated or indigent care, including income earned from endowment funds restricted for these purposes. This line is not currently considered in the uncompensated care cost determination.

Government Grants, Appropriations or Transfers for Support of Hospital Operations

Line 18 includes non-patient specific revenue received or expected from governmental entities for the cost reporting period for general operating support as well as funds for special purposes (including but not limited to funding uncompensated care). Funds for non-operating purposes, such as research or capital projects, should not be included. Include funds from the Federal Section 1011 program, which helps hospitals finance emergency health services for undocumented aliens. Report amounts received from charity care pools net of related provider taxes or assessments. This line is not currently considered in the uncompensated care cost determination.

Total Unreimbursed Cost for Medicaid, SCHIP and State and Local Indigent Care Programs

Line 19 calculates the total payment shortfall from Medicaid, SCHIP, and other state and local indigent care programs. This line is the total of line 8 (difference in Medicaid payments and cost), line 12 (difference in SCHIP payments and cost), and line 16 (difference in state or local indigent care program payments and cost). Hospitals are held harmless for payments in excess of costs for each of these categories. Unreimbursed cost is zero on lines 8, 12 or 16 instead of a negative amount if the payments are greater than the calculated cost.

Cost of Charity Care

Line 20 includes gross charges for care delivered during the cost reporting period for patients who qualified under the hospital's charity care policy for either full or partial write-off. The reported amount should include total charges not just the amount written off as charity. Charges should be split between uninsured (column 1) and insured patients (column 2). Courtesy discounts or charges paid or adjusted by insurance should not be included. Only the patient's responsibility (i.e., deductibles and coinsurance) should be included in the "insured patients" column. Patients with coverage from an entity that does not have a contractual relationship with the provider should be included in uninsured (column 1). Charges for non-covered services (including charges for days exceeding a length of stay limit) provided to patients covered by Medicaid or other indigent care programs can be included if specified in the hospital's charity care policy. Charity care charges for patient days beyond a length of stay limit is reported on both lines 20 and 25.

Line 22 includes patient payments or expected payments related to the charity care charges included on line 20. This includes the total paid by patients, due from patients, or written off to bad debts. Amounts written off as charity or indigent care should not be included.

Bad Debt Expense

Line 26 includes the amount of patient bad debts written off during the cost reporting period for the entire hospital complex. Charges written off should include all services except physician and other professional services. The reported amount must include Medicare bad debts claimed on the cost report because the amount reimbursed by Medicare is subtracted on line 28. Do not include amounts that were the obligation of the insurer rather than the patient.

Total Unreimbursed and Uncompensated Care Cost

Line 30 includes total uncompensated care cost, which is defined as charity care cost (calculated on line 23) plus the cost of non-Medicare and non-reimbursable Medicare bad debt expense (calculated on line 29). CMS has considered using this line for each hospital to determine Factor 3 of the uncompensated care payment formula.[9]

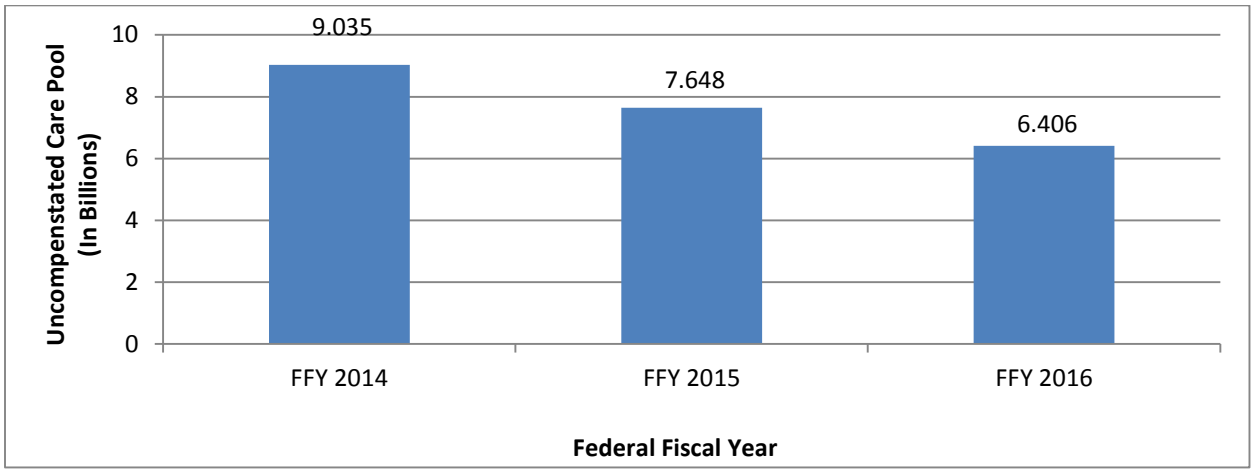
Line 31 includes total uncompensated care cost from line 30 plus total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs from line 19.

CONCLUSIONS AND RECOMMENDATIONS

The total uncompensated care payment amount proposed for federal fiscal year (FFY) 2016 is in excess of $6 billion but is $1.2 billion less than FFY 2015 and $2.6 billion less than FFY 2014. Graph 1 illustrates the declining availability of uncompensated care payments since its inception. Hospitals should be doing all they can to ensure they get their fair share of the allocation while complying with the reporting requirements. Providers should review their Worksheet S-10 data carefully before filing the cost report to ensure their data is complete and accurate in anticipation of CMS's reliance on this data to calculate their EHR incentive payments and for future uncompensated care pool allocations. Hospitals should also be mindful of other organizations analyzing cost report data, such as AIR 340B who used the cost of charity care reported on Worksheet S-10 to lobby Congress to reconsider 340B eligibility criteria.

[9] Federal Register, Vol. 78, No. 91, Page 27586, *FFY 2014 IPPS Proposed Rule*; May 10. 2013

Graph 1: Total Uncompensated Care Payments Available



Detailed patient lists and other documentation should be maintained to support Worksheet S-10 reported amounts in the event of an audit. At a minimum, the patient details should include patient name and account number, dates of service, total charges excluding professional fees, total patient payments, name of insurer(s), total insurance payments, contractual adjustments, deductibles, coinsurance, and bad debt and charity write-off dates and amounts.

Charity care reported on Worksheet S-10 must comply with the hospital's charity care policy. Hospitals should ensure all services that qualify as charity care are reported. If not already included, consideration should be given to modifying the hospital's charity care policy to allow for non-covered services provided to patients eligible for Medicaid or other indigent care programs. Charity care thresholds should be reviewed against cash collections to determine if a more generous charity care policy would be in order given that charity care is the focus of political advocacy groups rather than bad debt expense.

APPENDICES

Appendix A: Worksheet S-10 Examples

Example 1

Worksheet S-10: Example 1	Input line			
	Col. 1	**Col. 2**	**Col. 3**	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (W/S C Pt I L.202 C.3 divided by L.202 C.8)	0.231337			1
Medicaid				
2 Net revenue from Medicaid	161,347,657			2
3 Did you receive DSH or supplemental payments from Medicaid?	Y			3
4 If L.3 is yes, does L.2 include all Medicaid DSH or supplemental pymts?	N			4
5 If L.4 is no, then enter DSH or supplemental payments from Medicaid	90,073,398			5
6 Medicaid charges	580,346,254			6
7 Medicaid cost (line 1 times line 6)	134,255,561			7
8 Diff btwn net rev and costs for Medicaid (L.7 - L.2 - L.5; if <0 enter 0)	-			8
State Children's Health Insurance Program (SCHIP)				
9 Net revenue from stand-alone SCHIP	2,267,868			9
10 Stand-alone SCHIP charges	9,289,698			10
11 Stand-alone SCHIP cost (line 1 times line 10)	2,149,051			11
12 Diff btwn net rev and costs for SCHIP (L.11 - Ln 9; if < 0 enter 0)	-			12
Other state or local government indigent care program				
13 Net rev from state or local indigent care pgm (Not on lines 2, 5 or 9)	-			13
14 Chgs for pts covd under state or local ind care pgm (Not in L.6 or 10)	-			14
15 State or local indigent care program cost (line 1 times line 14)	-			15
16 Diff btwn net rev and costs for ind pgm (L.15 - L.13; if < 0 enter 0)	-			16
Uncompensated care				
17 Priv grants, donations, endowmt inc restricted to funding charity care	-			17
18 Govt grants, approp or transfers for support of hospital operations	87,718,266			18
19 Total unreimb cost for MD, SCHIP and ind pgm (sum of L.8,12,16)	-			19
	Uninsured patients	**Insured patients**	**Total (col. 1 + col. 2)**	
20 Total initial oblig of pts approved for charity care (full chg excl NRCC)	409,452,226	5,937,395	415,389,621	20
21 Cost of initial oblig of pts approved for charity care (Ln 1 X Ln 20)	94,721,450	1,373,539	96,094,989	21
22 Partial payment by patients approved for charity care	2,837,457	112,616	2,950,073	22
23 Cost of charity care (line 21 minus line 22)	91,883,993	1,260,923	93,144,916	23
24 Does L.20 incl chg for >LOS lmt for pts w/MD or other indigent pgm?	N			24
25 If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS limit	-			25
26 Total bad debt expense for the entire hospital complex	264,405,818			26
27 Medicare bad debts for the entire hospital complex	2,053,165			27
28 Non-MR and Non-Reimb MR bad debt expense (Ln 26 minus Ln 27)	262,352,653			28
29 Cost of non-MR and non-reimb MR bad debt exp (Ln 1 times line 28)	60,691,876			29
30 Cost of uncompensated care (Ln 23 Col. 3 plus Ln 29)	153,836,791			30
31 Total unreimbursed and uncompensated care cost (Ln 19 plus Ln 30)	153,836,791			31

Example 2

Worksheet S-10: Example 2	Input line Col. 1	Col. 2	Col. 3	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (W/S C Pt I L.202 C.3 divided by L.202 C.8)	0.165907			1
Medicaid				
2 Net revenue from Medicaid	36,103,000			2
3 Did you receive DSH or supplemental payments from Medicaid?	Y			3
4 If L.3 is yes, does L.2 include all Medicaid DSH or supplemental pymts?	N			4
5 If L.4 is no, then enter DSH or supplemental payments from Medicaid	-			5
6 Medicaid charges	331,846,671			6
7 Medicaid cost (line 1 times line 6)	55,055,686			7
8 Diff btwn net rev and costs for Medicaid (L.7 - L.2 - L.5; if <0 enter 0)	18,952,686			8
State Children's Health Insurance Program (SCHIP)				
9 Net revenue from stand-alone SCHIP	2,690,769			9
10 Stand-alone SCHIP charges	21,299,934			10
11 Stand-alone SCHIP cost (line 1 times line 10)	3,533,808			11
12 Diff btwn net rev and costs for SCHIP (L.11 - Ln 9; if < 0 enter 0)	843,039			12
Other state or local government indigent care program				
13 Net rev from state or local indigent care pgm (Not on lines 2, 5 or 9)	9,040,179			13
14 Chgs for pts covd under state or local ind care pgm (Not in L.6 or 10)	208,908,938			14
15 State or local indigent care program cost (line 1 times line 14)	34,659,455			15
16 Diff btwn net rev and costs for ind pgm (L.15 - L.13; if < 0 enter 0)	25,619,276			16
Uncompensated care				
17 Priv grants, donations, endowmt inc restricted to funding charity care	-			17
18 Govt grants, approp or transfers for support of hospital operations	126,026,484			18
19 Total unreimb cost for MD, SCHIP and ind pgm (sum of L.8,12,16)	45,415,001			19
	Uninsured patients	**Insured patients**	**Total (col. 1 + col. 2)**	
20 Total initial oblig of pts approved for charity care (full chg excl NRCC)	155,593,060	240,125,700	395,718,760	20
21 Cost of initial oblig of pts approved for charity care (Ln 1 X Ln 20)	25,813,978	39,838,535	65,652,512	21
22 Partial payment by patients approved for charity care	410,528	52,199	462,727	22
23 Cost of charity care (line 21 minus line 22)	25,403,450	39,786,336	65,189,785	23
24 Does L.20 incl chg for >LOS lmt for pts w/MD or other indigent pgm?	N			24
25 If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS limit	-			25
26 Total bad debt expense for the entire hospital complex	43,675,653			26
27 Medicare bad debts for the entire hospital complex	3,255,499			27
28 Non-MR and Non-Reimb MR bad debt expense (Ln 26 minus Ln 27)	40,420,154			28
29 Cost of non-MR and non-reimb MR bad debt exp (Ln 1 times line 28)	6,705,986			29
30 Cost of uncompensated care (Ln 23 Col. 3 plus Ln 29)	71,895,772			30
31 Total unreimbursed and uncompensated care cost (Ln 19 plus Ln 30)	117,310,773			31

Example 3

Worksheet S-10: Example 3	Input line Col. 1	Col. 2	Col. 3	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (W/S C Pt I L.202 C.3 divided by L.202 C.8)	0.722629			1
Medicaid				
2 Net revenue from Medicaid	604,817			2
3 Did you receive DSH or supplemental payments from Medicaid?	N			3
4 If L.3 is yes, does L.2 include all Medicaid DSH or supplemental pymts?	N			4
5 If L.4 is no, then enter DSH or supplemental payments from Medicaid	-			5
6 Medicaid charges	1,283,944			6
7 Medicaid cost (line 1 times line 6)	927,815			7
8 Diff btwn net rev and costs for Medicaid (L.7 - L.2 - L.5; if <0 enter 0)	322,998			8
State Children's Health Insurance Program (SCHIP)				
9 Net revenue from stand-alone SCHIP	37,761			9
10 Stand-alone SCHIP charges	70,765			10
11 Stand-alone SCHIP cost (line 1 times line 10)	51,137			11
12 Diff btwn net rev and costs for SCHIP (L.11 - Ln 9; if < 0 enter 0)	13,376			12
Other state or local government indigent care program				
13 Net rev from state or local indigent care pgm (Not on lines 2, 5 or 9)	-			13
14 Chgs for pts covd under state or local ind care pgm (Not in L.6 or 10)	-			14
15 State or local indigent care program cost (line 1 times line 14)	-			15
16 Diff btwn net rev and costs for ind pgm (L.15 - L.13; if < 0 enter 0)	-			16
Uncompensated care				
17 Priv grants, donations, endowmt inc restricted to funding charity care	-			17
18 Govt grants, approp or transfers for support of hospital operations	186,678			18
19 Total unreimb cost for MD, SCHIP and ind pgm (sum of L.8,12,16)	336,374			19
	Uninsured patients	**Insured patients**	**Total (col. 1 + col. 2)**	
20 Total initial oblig of pts approved for charity care (full chg excl NRCC)	196,943	35,313	232,256	20
21 Cost of initial oblig of pts approved for charity care (Ln 1 X Ln 20)	142,317	25,518	167,835	21
22 Partial payment by patients approved for charity care	10,066	1,805	11,871	22
23 Cost of charity care (line 21 minus line 22)	132,251	23,713	155,964	23
24 Does L.20 incl chg for >LOS lmt for pts w/MD or other indigent pgm?	N			24
25 If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS limit	-			25
26 Total bad debt expense for the entire hospital complex	844,609			26
27 Medicare bad debts for the entire hospital complex	155,525			27
28 Non-MR and Non-Reimb MR bad debt expense (Ln 26 minus Ln 27)	689,084			28
29 Cost of non-MR and non-reimb MR bad debt exp (Ln 1 times line 28)	497,952			29
30 Cost of uncompensated care (Ln 23 Col. 3 plus Ln 29)	653,916			30
31 Total unreimbursed and uncompensated care cost (Ln 19 plus Ln 30)	990,290			31

Example 4

Worksheet S-10: Example 4	Input line Col. 1	Col. 2	Col. 3	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (W/S C Pt I L.202 C.3 divided by L.202 C.8)	0.250087			1
Medicaid				
2 Net revenue from Medicaid	10,598,696			2
3 Did you receive DSH or supplemental payments from Medicaid?	Y			3
4 If L.3 is yes, does L.2 include all Medicaid DSH or supplemental pymts?	N			4
5 If L.4 is no, then enter DSH or supplemental payments from Medicaid	833,525			5
6 Medicaid charges	40,300,295			6
7 Medicaid cost (line 1 times line 6)	10,078,580			7
8 Diff btwn net rev and costs for Medicaid (L.7 - L.2 - L.5; if <0 enter 0)	-			8
State Children's Health Insurance Program (SCHIP)				
9 Net revenue from stand-alone SCHIP	306,024			9
10 Stand-alone SCHIP charges	1,277,871			10
11 Stand-alone SCHIP cost (line 1 times line 10)	319,579			11
12 Diff btwn net rev and costs for SCHIP (L.11 - Ln 9; if < 0 enter 0)	13,555			12
Other state or local government indigent care program				
13 Net rev from state or local indigent care pgm (Not on lines 2, 5 or 9)	-			13
14 Chgs for pts covd under state or local ind care pgm (Not in L.6 or 10)	-			14
15 State or local indigent care program cost (line 1 times line 14)	-			15
16 Diff btwn net rev and costs for ind pgm (L.15 - L.13; if < 0 enter 0)	-			16
Uncompensated care				
17 Priv grants, donations, endowmt inc restricted to funding charity care	-			17
18 Govt grants, approp or transfers for support of hospital operations	2,295,006			18
19 Total unreimb cost for MD, SCHIP and ind pgm (sum of L.8,12,16)	13,555			19
	Uninsured patients	**Insured patients**	**Total (col. 1 + col. 2)**	
20 Total initial oblig of pts approved for charity care (full chg excl NRCC)	21,008,971	-	21,008,971	20
21 Cost of initial oblig of pts approved for charity care (Ln 1 X Ln 20)	5,254,071	-	5,254,071	21
22 Partial payment by patients approved for charity care	3,875	-	3,875	22
23 Cost of charity care (line 21 minus line 22)	5,250,196	-	5,250,196	23
24 Does L.20 incl chg for >LOS lmt for pts w/MD or other indigent pgm?	N			24
25 If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS limit	-			25
26 Total bad debt expense for the entire hospital complex	1,711,675			26
27 Medicare bad debts for the entire hospital complex	184,990			27
28 Non-MR and Non-Reimb MR bad debt expense (Ln 26 minus Ln 27)	1,526,685			28
29 Cost of non-MR and non-reimb MR bad debt exp (Ln 1 times line 28)	381,804			29
30 Cost of uncompensated care (Ln 23 Col. 3 plus Ln 29)	5,632,000			30
31 Total unreimbursed and uncompensated care cost (Ln 19 plus Ln 30)	5,645,555			31

Example 5

Worksheet S-10: Example 5	Input line Col. 1	Col. 2	Col. 3	
Uncompensated and indigent care cost computation				
1 Cost to charge ratio (W/S C Pt I L.202 C.3 divided by L.202 C.8)	0.547835			1
Medicaid				
2 Net revenue from Medicaid	367,079			2
3 Did you receive DSH or supplemental payments from Medicaid?	Y			3
4 If L.3 is yes, does L.2 include all Medicaid DSH or supplemental pymts?	N			4
5 If L.4 is no, then enter DSH or supplemental payments from Medicaid	-			5
6 Medicaid charges	1,231,392			6
7 Medicaid cost (line 1 times line 6)	674,600			7
8 Diff btwn net rev and costs for Medicaid (L.7 - L.2 - L.5; if <0 enter 0)	307,521			8
State Children's Health Insurance Program (SCHIP)				
9 Net revenue from stand-alone SCHIP	-			9
10 Stand-alone SCHIP charges	-			10
11 Stand-alone SCHIP cost (line 1 times line 10)	-			11
12 Diff btwn net rev and costs for SCHIP (L.11 - Ln 9; if < 0 enter 0)	-			12
Other state or local government indigent care program				
13 Net rev from state or local indigent care pgm (Not on lines 2, 5 or 9)	-			13
14 Chgs for pts covd under state or local ind care pgm (Not in L.6 or 10)	-			14
15 State or local indigent care program cost (line 1 times line 14)	-			15
16 Diff btwn net rev and costs for ind pgm (L.15 - L.13; if < 0 enter 0)	-			16
Uncompensated care				
17 Priv grants, donations, endowmt inc restricted to funding charity care	-			17
18 Govt grants, approp or transfers for support of hospital operations	802,946			18
19 Total unreimb cost for MD, SCHIP and ind pgm (sum of L.8,12,16)	307,521			19
	Uninsured patients	**Insured patients**	**Total (col. 1 + col. 2)**	
20 Total initial oblig of pts approved for charity care (full chg excl NRCC)	987,097	32,368	1,019,465	20
21 Cost of initial oblig of pts approved for charity care (Ln 1 X Ln 20)	540,766	17,732	558,499	21
22 Partial payment by patients approved for charity care	2,902	1,566	4,468	22
23 Cost of charity care (line 21 minus line 22)	537,864	16,166	554,031	23
24 Does L.20 incl chg for >LOS lmt for pts w/MD or other indigent pgm?	N			24
25 If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS limit	-			25
26 Total bad debt expense for the entire hospital complex	1,731,592			26
27 Medicare bad debts for the entire hospital complex	166,233			27
28 Non-MR and Non-Reimb MR bad debt expense (Ln 26 minus Ln 27)	1,565,359			28
29 Cost of non-MR and non-reimb MR bad debt exp (Ln 1 times line 28)	857,558			29
30 Cost of uncompensated care (Ln 23 Col. 3 plus Ln 29)	1,411,589			30
31 Total unreimbursed and uncompensated care cost (Ln 19 plus Ln 30)	1,719,110			31

Appendix B: CMS Definitions and Instructions

4012. Worksheet S-10 - Hospital Uncompensated and Indigent Care Data--Section 112(b) of the Balanced Budget Refinement Act (BBRA) requires that short-term acute care hospitals (§1886(d) of the Act) submit cost reports containing data on the cost incurred by the hospital for providing inpatient and outpatient hospital services for which the hospital is not compensated. Charity care charge data, as referenced in section 4102 of American Recovery and Reinvestment Act of 2009, may be used to calculate the EHR technology incentive payments made to §1886(d) hospitals and critical access hospitals (CAHs). CAHs, as well as §1886(d) hospitals, are required to complete this worksheet. Note that this worksheet does not produce the estimate of the cost of treating uninsured patients required for disproportionate share payments under the Medicaid program.

Definitions

Uncompensated care--Defined as charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances or discounts given to patients.

Charity care--Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital's policy to provide all or a portion of services free of charge to patients who meet certain financial criteria. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt. (Additional guidance provided in the instruction for line 20.)

Non-Medicare bad debt--Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim. (Additional guidance provided in the instruction for line 25.)

Non-reimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1. (Additional guidance provided in the instruction for line 25.)

Net revenue--Actual payments received or expected to be received from a payer (including co-insurance payments from the patient) for services delivered during

this cost reporting period. Net revenue will typically be charges (gross revenue) less contractual allowance. (Applies to lines 2, 9, and 13.)

Instructions

Cost to Charge Ratio

Line 1--Enter the cost-to-charge ratio resulting from Worksheet C, Part I, line 202, column 3 divided by Worksheet C, Part I, line 202, column 8.

For all inclusive rate providers that do not complete Worksheet C, Part I, enter your cost-to-charge ratio as calculated in accordance with CMS Pub. 15-1, section 2208.

Medicaid

NOTE: The amount on line 18 should not include the amounts on lines 2 and 5. That is, the amounts on lines 2 and 5 are mutually exclusive from the amount on line 18.

Line 2--Enter the inpatient and outpatient payments received or expected for Title XIX covered services delivered during this cost reporting period. Include payments for an expansion SCHIP program, which covers recipients who would have been eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include payments received from Medicaid managed care programs. If not separately identifiable, disproportionate share (DSH) and supplemental payments should be included in this line. For these payments, report the amount received or expected for the cost reporting period, net of associated provider taxes or assessments.

Line 3--Enter "Y" for yes if you received or expect to receive any DSH or supplemental payments from Medicaid relating to this cost reporting period. Otherwise enter "N" for no.

Line 4--If you answered yes to question 3, enter "Y" for yes if all of the DSH or supplemental payments you received from Medicaid are included in line 2. Otherwise enter "N" for no and complete line 5.

Line 5--If you answered no to question 4, enter the DSH or supplemental payments the hospital received or expects to receive from Medicaid relating to this cost reporting period that were not included in line 2, net of associated provider taxes or assessments.

Line 6--Enter all charges (gross revenue) for Title XIX covered services delivered during this cost reporting period. These charges should relate to the services for which payments were reported on line 2.

Line 7--Calculate the Medicaid cost by multiplying line 1 times line 6.

Line 8--Enter the difference between net revenue and costs for Medicaid by subtracting the sum of lines 2 and 5 from line 7. If line 7 is less than the sum of lines 2 and 5, then enter zero.

State Children's Health Insurance Program

Line 9--Enter all payments received or expected for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. Stand-alone SCHIP programs cover recipients who are not eligible for coverage under Title XIX. Include payments for all covered services except physician or other professional services, and include any payments received from SCHIP managed care programs.

Line 10--Enter all charges (gross revenue) for services delivered during this cost reporting period that were covered by a stand-alone SCHIP program. These charges should relate to the services for which payments were reported on line 9.

Line 11--Calculate the stand-alone SCHIP cost by multiplying line 1 times line 10.

Line 12--Enter the difference between net revenue and costs for stand-alone SCHIP by subtracting line 9 from line 11. If line 11 is less than line 9, then enter zero.

Other state or local indigent care program:

Line 13--Enter all payments received or expected for services delivered during this cost reporting period for patients covered by a state or local government indigent care program (other than Medicaid or SCHIP), where such payments and associated charges are identified with specific patients and documented through the provider's patient accounting system. Include payments for all covered services except physician or other professional services, and include payments from managed care programs.

Line 14--Enter all charges (gross revenue) for services delivered during this cost reporting period for patients covered by a state or local government program, where such charges and associated payments are documented through the provider's patient accounting system. These charges should relate to the services for which payments were reported on line 13.

Line 15--Calculate the costs for patients covered by a state or local government program by multiplying line 1 times line 14.

Line 16--Calculate the difference between net revenue and costs for patients covered by a state or local government program by subtracting line 13 from line 15. If line 15 is less than line 13, then enter zero.

Uncompensated Care

Line 17--Enter the value of all non-government grants, gifts and investment income received during this cost reporting period that were restricted to funding uncompensated or indigent care. Include interest or other income earned from any endowment fund for which the income is restricted to funding uncompensated or indigent care.

Line 18--Enter all grants, appropriations or transfers received or expected from government entities for this cost reporting period for purposes related to operation of the hospital, including funds for general operating support as well as for special purposes (including but not limited to funding uncompensated care). Include funds from the Federal Section 1011 program, if applicable, which helps hospitals finance emergency health services for undocumented aliens. While Federal Section 1011 funds were allotted for federal fiscal years 2005 through 2008, any unexpended funds will remain available after that time period until fully expended even after federal fiscal year 2008. If applicable, report amounts received from charity care pools net of related provider taxes or assessments. Do not include funds from government entities designated for non-operating purposes, such as research or capital projects.

Line 19--Calculate the total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs by entering the sum of lines 8, 12 and 16.

Line 20--Enter the total initial payment obligation of patients who are given a full or partial discount based on the hospital’s charity care criteria (measured at full charges), for care delivered during this cost reporting period for the entire facility. For uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider (column 1), this is the patient’s total charges. For patients covered by a public program or private insurer with which the provider has a contractual relationship (column 2), these are the deductible and coinsurance payments required by the payer. Include charity care for all services except physician and other professional services. Do not include charges for either uninsured patients given discounts without meeting the hospital's

charity care criteria or patients given courtesy discounts. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care program (including charges for days exceeding a length of stay limit) can be included, if such inclusion is specified in the hospital's charity care policy and the patient meets the hospital's charity care criteria.

Line 21--Calculate the cost of initial obligation of patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 22--Enter payments received or expected from patients who have been approved for partial charity care for services delivered during this cost reporting period. Include such payments for all services except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 23--Calculate the cost of charity care by subtracting line 22 from line 21. Use column 1 for uninsured patients, including patients with coverage from an entity that does not have a contractual relationship with the provider, and use column 2 for patients covered by a public program or private insurer with which the provider has a contractual relationship.

Line 24--Enter “Y” for yes if any charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program are included in the amount reported in line 20, column 2, and complete line 25. Otherwise enter “N” for no.

Line 25--If you answered yes to question 24, enter charges for patient days beyond a length-of-stay limit imposed on patients covered by Medicaid or other indigent care program for services delivered during this cost reporting period. The amount must match the amount of such charges included in line 20, column 2.

Line 26--Enter the total facility (entire hospital complex) amount of bad debts written off on balances owed by patients during this cost reporting period. Include such bad debts for all services except physician and other professional services. The amount reported must also include the amounts reported on Worksheets: E, Part A,

line 64; E, Part B, line 34; E-2, line 17, columns 1 and 2; E-3, Part I, line 11; E-3, Part II, line 23; E-3, Part III, line 24; E-3, Part IV, line 14; E-3, Part V, line 25; E-3, Part VI, line 8; E-3, Part VII, line 34; I-5, line 5 (line 5.05, column 2 for cost reporting periods that overlap or begin on or after or January 1, 2011); J-3, line 21; and M-3, line 23. For privately insured patients, do not include bad debts that were the obligation of the insurer rather than the patient.

Line 27--Enter the total facility (entire hospital complex) Medicare reimbursable (also referred to adjusted) bad debts as the sum of Worksheet E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 (line 17.01, columns 1 and 2 for cost reporting periods that begin on or after October 1, 2012); E-3, Part I, line 12; E-3, Part II, line 24; E-3, Part III, line 25; E-3, Part IV, line 15; E-3, Part V, line 26; E-3, Part VI, line 10; I-5, line 11; J-3, line 21 (line 22 for cost reporting periods that begin on or after October 1, 2012); and M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012).

Line 28--Calculate the non-Medicare and non-reimbursable Medicare bad debt expense by subtracting line 27 from line 26.

Line 29--Calculate the cost of non-Medicare and non-reimbursable Medicare bad debt expense by multiplying line 1 times line 28.

Line 30--Calculate the cost of uncompensated care by entering the sum of lines 23, column 3 and line 29.

Line 31--Calculate the cost of unreimbursed and uncompensated care and by entering the sum of lines 19 and 30.

Appendix C: Resources

The National Rural Health Resource Center (The Center) provides access to the Health Education and Learning Program (HELP) webinar library. The Center's HELP webinar library provides rural hospitals access to a wide range of trainings. The previously recorded HELP webinars are available to rural hospitals at no cost to assist them with improving and sustaining financial, operational, and quality performance. These trainings are developed to support the executive team and are targeted to the front-line staff, supervisors, managers and board members. The Center also maintains a resource library of presentations, articles and toolkits developed by trusted industry leaders. These online resources are available to rural hospitals at http://www.ruralcenter.org/resource-library.