Draffin & Tucker, LLP
CERTIFIED PUBLIC ACCOUNTANTS

Understanding the S-10 Worksheet (Part 1 of 2)

Guide to Completing Worksheet S-10

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Disclaimer

The information presented is intended to provide 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 presentation. Every effort has been made to assure the accuracy of these materials. Draffin & Tucker, LLP and the authors do not assume responsibility for any individual's reliance upon the information provided. 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.

Additional Resource

For more information on preparing Worksheet S-10, please see the National Rural Health Resource Center's Small Rural Hospital Transition (SRHT) Project Guide "Understanding the Hospital Medicare Cost Report Uncompensated and Indigent Care Data Form (Form CMS-2552-10, Worksheet S-10)"

What is Worksheet S-10?

A form in the Medicare cost report used to gather data on the cost incurred by hospitals for providing patient care services for which the hospital is not compensated

Who completes Worksheet S-10?

- Hospitals paid under the prospective payment system
- Critical access hospitals

What costs are included?

- Medicaid
- State Children's Health Insurance Program (SCHIP)
- Other state or local government indigent care programs
- Charity care
- Bad debts

How are costs calculated?

- The hospital's overall cost-to-charge ratio is multiplied by charges (gross revenue) to calculate costs
- Payments are subtracted from costs to calculate unreimbursed cost (payment shortfall) and uncompensated care cost

What services are included?

- The entire hospital facility or complex
  - Include all cost centers reported on Worksheet C
- Physician or other professional services are not included
  - Exclude services billed under Part B
  - Exclude non-reimbursable cost centers

Line 1: Cost-to-Charge Ratio

Worksheet C, Line 202, Column 3
(Total Allowable Costs)

divided by

Worksheet C, Line 202, Column 8
(Total Charges)

Line 2: Net revenue from Medicaid

- Actual payments received or expected for Title XIX covered services delivered during the cost reporting period
- Include fee-for-service, out-of-state, and managed care primary payor claims
- Include deductibles and coinsurance
- Cost report settlements should be considered

Lines 3 through 5: Medicaid DSH and supplemental payments

- Line 3: Answer Yes or No if you received any Medicaid DSH or supplemental payments
- Line 4: Answer Yes or No if Line 2 includes all Medicaid DSH or supplemental payments
- Line 5: Enter Medicaid DSH or supplemental payments not included in Line 2
  - Enter payments received or expected, net of intergovernmental transfers, related to the cost reporting period

Line 6: Medicaid charges

- Include all charges (gross revenue) for Title XIX covered services delivered during the cost reporting period
  - Charges are associated with the payments included on Line 2
  - Ensure expected payments are estimated on Line 2 for all unpaid accounts

Line 7: Medicaid cost

Line 1 cost-to-charge ratio

times

Line 6 Medicaid charges

Line 8: Unreimbursed Medicaid cost

- Line 7 Medicaid cost minus the sum of Line 2 net revenue from Medicaid and Line 5 Medicaid DSH and supplemental payments
- This line is zero if Medicaid payments exceed cost

Lines 2 through 8: Medicaid

Ln	Medicaid Unreimbursed Cost Calculation	Col. 1	Ln
1	Cost to charge ratio (W/S C Pt I Ln 202 Col. 3 div. by Ln 202 Col. 8)	0.231337	1
2	Net revenue from Medicaid	161,347,657	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is "yes", does Ln 2 include all DSH or supplemental pymts from MD?	N	4
5	If line 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 btw net rev and costs for MD (Ln 7 – Ln 2 – Ln 5; if < 0 enter 0)	0	8

Line 9: Net revenue from stand-alone SCHIP

- Actual payments received or expected for Title XXI covered services delivered during the cost reporting period
- Include fee-for-service, out-of-state, and managed care primary payor claims
- Include deductibles and coinsurance
- Cost report settlements should be considered

Line 10: Stand-alone SCHIP charges

- Include all charges (gross revenue) for Title XXI covered services delivered during the cost reporting period
  - Charges are associated with the payments included on Line 9
  - Ensure expected payments are estimated on Line 9 for all unpaid accounts

Line 11: Stand-alone SCHIP cost

Line 1 cost-to-charge ratio

times

Line 10 stand-alone SCHIP charges

Line 12: Unreimbursed stand-alone SCHIP cost

- Line 11 stand-alone SCHIP cost minus Line 9 net revenue from stand-alone SCHIP
- This line is zero if SCHIP payments exceed cost

Lines 9 through 12: SCHIP

Ln	Uncompensated and indigent care cost computation	Col. 1	Ln
1	Cost to charge ratio (W/S C Pt I L.202 C.3 div. by L.202 C.8)	0.231337	1
	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 btw net rev and costs for SCHIP (L.11 - L.9; if <0 enter 0)	0	12

Line 13: Net revenue from state or local indigent care program

- Actual payments received or expected for services delivered during the cost reporting period
- Do not include amounts already included on Lines 2, 5 or 9
- Related to specific patient accounts documented through the patient accounting system
- Include deductibles and coinsurance

Line 14: State or local indigent care program charges

- Include all charges (gross revenue) for services delivered during the cost reporting period for patients covered under government indigent care programs (other than Medicaid or SCHIP)
  - Charges are associated with the payments included on Line 13
  - Ensure expected payments are estimated on Line 13 for all unpaid accounts

Line 15: State or local indigent care program cost

Line 1 cost-to-charge ratio

times

Line 14 state or local government indigent care program charges

Line 16: Unreimbursed state or local indigent care program cost

- Line 15 state or local indigent care program cost minus Line 13 net revenue from state or local indigent care program
- This line is zero if state or local indigent care program payments exceed cost

Lines 13 through 16: Other indigent care programs

Ln	Uncompensated and indigent care cost computation	Col. 1	Ln
1	Cost to charge ratio (W/S C Pt I Ln 202 Col. 3 div. by Ln 202 Col. 8)	0.231337	1
	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)	500,000	13
14	Chgs for pts covd under state or local ind care pgm (Not in Ln 6 or 10)	1,000,000	14
15	State or local indigent care program cost (line 1 times line 14)	231,337	15
16	Diff btw net rev and costs for other ind pgm (L.15 – L.13; if <0 enter 0)	0	16

Line 17: Private grants, donations, or endowment income restricted to funding charity care

- Not currently considered in the uncompensated care cost determination
- Include 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

Line 18: Government grants, appropriations or transfers for support of hospital operations

- Not currently considered in the uncompensated care cost determination
- Include non-patient specific revenue received or expected from governmental entities for the cost reporting period for purposes related to operation of the hospital
- Not limited to uncompensated care funding

Line 18: Government grants, appropriations or transfers for support of hospital operations (continued)

- Do not include funds for non-operating purposes such as research or capital projects
- Include Federal Section 1011 funds (funding for emergency health services for undocumented aliens)
- Report amounts received from charity care pools net of related provider taxes or assessments

Line 19: Total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs

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

Lines 17 through 19: Unreimbursed cost for Medicaid, SCHIP, and other indigent care programs

Ln	Uncompensated care	Col. 1	Ln
17	Priv grants, donations, endowmt inc rest to funding charity care	0	17
18	Govt grants, approp or transfers for support of hospital operations	87,718,266	18
19	Total unreimb cost for MD, SCHIP, other ind pgm (sum of L.8, 12, 16)	0	19

Line 20: Charity care charges

- Include 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
- Include total charges, not just the amount written off as charity

Line 20: Charity care charges (Noncovered Services)

- Charges for noncovered services 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 20: Charity care charges (Uninsured Patients)

Column 1 includes uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider

Line 20: Charity care charges (Insured Patients)

Column 2 includes the patient's responsibility only

- Deductible and coinsurance payments required by the payer

Line 21: Cost of initial obligation of patients approved for charity care

Line 1 cost-to-charge ratio

times

Line 20 initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers)

Line 22: Payments by patients approved for charity care

- Include patient payments or expected payments related to the charity care charges included on Line 20
- Include the total paid by patients, due from patients, or written off to bad debts
  - Bad debts are included on Line 26 also
- Do not include amounts written off as charity or indigent care

Line 23: Cost of charity care

Line 21 cost of initial obligation of patients approved for charity care

minus

Line 22 payments received or expected from patients approved for partial charity care

Line 24: Charges for patient days beyond a length of stay limit

- Answer Yes if Line 20, Column 2 includes charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program
- May only be included if specified in the hospital's charity care policy

Line 25: Charges for patient days beyond a length of stay limit

If Line 24 is Yes, report the charges included in Line 20 for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program

Lines 20 through 25: Charity care

Ln	Uncompensated and indigent care cost computation	Col. 1	Col. 2	Col. 3	Ln
1	Cost to charge ratio (W/S C Pt I L.202 C.3 div. by L.202 C.8)	0.231337			1
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
20	Total initial oblig of pts approved for charity care (full chg)	409,452,226	5,937,395	415,389,621	20
21	Cost of initial oblig of pts approved for charity care (L.1 X L.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 with MD/oth ind care pgm?	N			24
25	If Ln 24 is yes, chgs for pt days beyond an ind care pgm's LOS lmt	0			25

Line 26: Total bad debt expense

- Include the amount of patient bad debts written off during the cost reporting period
- All other S-10 lines, including charity care, report services delivered during the cost reporting period

Line 26: Total bad debt expense (continued)

- Include Medicare bad debts claimed on the cost report
- Do not include bad debts that were the obligation of the insurer rather than the patient

Line 27: Medicare bad debts

- Include Medicare reimbursable bad debts
- This is the sum of all Medicare bad debt payments computed on the cost report for all types of services

Line 28: Net unreimbursed bad debt expense

Line 26 total bad debt expense

minus

Line 27 Medicare reimbursable bad debts

Line 29: Cost of Net unreimbursed bad debts

Line 1 cost-to-charge ratio

times

Line 28 non-Medicare and non-reimbursable Medicare bad debt expense

Lines 26 through 29: Bad debts

Ln	Uncompensated and indigent care cost computation	Col. 1	Ln
1	Cost to charge ratio (W/S C Pt I Ln 202 Col. 3 div. by Ln 202 Col. 8)	0.231337	1
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 (L.1 times L.28)	60,691,876	29

Line 30: Cost of uncompensated care

Line 23, Column 3 total cost of charity care for uninsured and insured patients

plus

Line 29 cost of non-Medicare and non-reimbursable Medicare bad debt expense

Line 31: Total unreimbursed and uncompensated care

Line 19 total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs

plus

Line 30 cost of uncompensated care (charity care and unreimbursed bad debt expense)

Lines 30 and 31: Total unreimbursed and uncompensated care cost

Ln	Uncompensated and indigent care cost computation	Col. 1	Col. 2	Col. 3	Ln
1	Cost to charge ratio (W/S C Pt I L.202 C.3 div. by L.202 C.8)	0.231337			1
19	Unreimb cost for MD, SCHIP, oth ind pgm (L.8+L.12+L.16)	0			19
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
23	Cost of charity care (line 21 minus line 22)	91,883,993	1,260,923	93,144,916	23
29	Cost of non-MR and non-reimb MR bad debt (L.1 X L.28)	60,691,876			29
30	Cost of non-Medicare uncompensated care (L.23 C.3 + L.29)	153,836,791			30
31	Total unreimb and uncomp care cost (L.19 + L.30)	153,836,791			31

Best Practices – Tip #1

Maintain patient details and other support in the event of an audit

Best Practices – Tip #2

Reconcile patient detail totals to general ledger accounts and/or third party reports (e.g., Medicaid paid claims reports)

Best Practices – Tip #3

- Ensure reported charity care complies with the hospital's charity care policy
  - Do not include charges for either uninsured patients given discounts without meeting the hospital's charity care criteria or patients given courtesy discounts

Best Practices – Tip #4

Review charity care thresholds against cash collections to determine if a more generous charity care policy would be in order

Best Practices – Tip #5

If not already included, consider modifying charity care policy to allow for non-covered services provided to patients eligible for Medicaid or other indigent care programs

Best Practices – Tip #6

Include charity care written off after fiscal year end if services were delivered during the cost reporting period

Best Practices – Tip #7

Ensure charity care is reported at full charges, not just the amount written off as charity

Best Practices – Tip #8

- Ensure only Medicare bad debts that comply with regulations are included on the cost report
  - Worksheet S-10 will be updated for amounts disallowed during desk review but CMS indicated unaudited data may be used to allocate uncompensated care payments in the future

Best Practices – Tip #9

Ensure reported amounts are net of any taxes or payments made in order to generate the funds (e.g., Medicaid DSH should be net of intergovernmental transfers)

Best Practices – Tip #10

- Review instructions carefully to ensure amounts are reported on the correct line
  - Lines 18 and 19 are currently not considered in the uncompensated care cost calculation

Questions?

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