Delta Region Community Health Systems Development Program

Understanding the Purpose, Preparation, and Utilization of the CMS Worksheet S-10

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National Rural Health Resource Center

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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 (SORH) Directors and Flex Program Coordinators in gaining a better understanding so 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), FORVIS 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 directive before recommending to a hospital or implementing on the hospital's behalf.

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Introduction

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. Hospital teams will learn what 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 of 1999 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. In 2009, CMS developed Worksheet S-10 of the Medicare hospital cost report to capture the required data. The S-10 has been a required schedule on the Hospital cost report since May 1, 2010. However, the schedule was not used to calculate Uncompensated Care reimbursement until Federal Fiscal 2018. In anticipation of this change, CMS issued instructions for completing the schedule in 2017. These more refined instructions included clarifications regarding the definitions of charity and bad debt, as well as definition of the fical time frame for the uncompensated care to be collected.

Hospitals paid under the inpatient prospective payment system (IPPS) and CAHs are required to complete Worksheet S-10. As the Worksheet S-10 is a schedule within the Medicare cost report, the timeframe for its completion follows the same timeline as the cost report. The cost report for all Medicare entities is 5 months after the fiscal year end. For example, if the hospital's fiscal year end is June 30, the due date for the cost report, and all supporting schedules will be November 30.

As detailed below, the primary entries in the Worksheet S-10 that are used for Uncompensated Care reimbursement are the charity care and bad debts entries on lines 20-26 of the schedule. These

amounts are to be supported by detailed patient listings including the write-off amounts and the other transactions related to the patient's account such as charges, payments and other adjustments. It is important to note that these write-offs may be related to services dates in the past, but that the requirement is to report all related data regardless of service date.

The S-10 will capture all charity and bad debt transactions, meeting specific definitions outlined here, which were written off during the fiscal year being reported.

Instructions for completing the worksheet are available on CMS's website.[1] Guidance on how to access these instructions can be found in Appendix B.

Utilization of Worksheet S-10

Disproportionate Share Hospital (DSH) Payment Methodology

Medicare DSH hospitals receive an additional Medicare inpatient payment for treating a disproportionate share of low-income patients. This payment, treated as an add-on payment to the hospital's inpatient DRG payment, was designed to compensate hospitals for the higher cost of treating low-income patients. This payment is only available to hospitals reimbursed using PPS methodology and would exclude CAHs.

Prior to October 1, 2013, 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

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

payments will receive an uncompensated care pool allocation based on its share of the total amount of uncompensated care for all Medicare DSH hospitals.

Uncompensated Care (UCC) Reimbursement Calculations

The available UCC funding for a given federal fiscal year is often referred to as the "UCC Pool" which is actuarily determined by CMS and published in the IPPS Rules for each federal fiscal year. It is common for the UCC pool to be approximately $10 billion.

Each hospital's portion of the UCC pool is determined by its "Factor 3 ratio" that is driven by Worksheet S-10 reporting. Factor 3 is intended to be proportional to the hospital's UCC compared to all other hospitals that qualify for DSH. When the hospital's Factor 3 is multiplied by the UCC pool, the result is the total UCC payment the hospital is entitled to in a given fiscal year.

Since Federal Fiscal 2014, CMS has worked to refine the process for determining each hospital's Factor 3. This methodology continues to evolve and is generally based on a combination of previous years' audited S-10 data as available, incorporating a scaling factor to normalize hospital fiscal years.

Worksheet S-10 Total Cost of Uncompensated Care

Worksheet S-10 calculates the unreimbursed cost/payment shortfalls, if any, of providing services to Medicaid, State Children's Health Insurance Program (SCHIP), and other indigent care program patients (Lines 8, 12, and 16, respectively). Amounts reported on these lines are not considered in the Medicare DSH payment methodology, and therefore will not be discussed in detail here.

Refer to Appendix A for examples of a completed Worksheet S-10 with data from actual cost reports filed by hospitals, and Appendix B for full CMS instructions related to these entries. Please note the completed lines in the examples do not necessarily 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 provided. The CCR is applied to uninsured charity and total bad debts reported.

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 (RHC)) except physician or other professional services.

Cost of Charity Care

The definitions of charity care have been refined over time, and the guidance has changed based on the cost reporting dates. The primary guiding principle is that charity care is to be claimed in the year it was written off, net of recoveries if the hospital is following its own charity policy. Nothing can be claimed if charity care is not consistent with the hospital's charity policy regardless of the below.

Line 20 includes total 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. These amounts always exclude any courtesy discounts or professional services. In many cases, this includes a self-pay discount if the requirements for this discount are included in the charity care or financial assistance policy (FAP). These total charge amounts include only the amount the patient qualifies for charity, and in practice, is usually reported by summarizing the charity care write-offs during the year, net of recoveries. Charges should be split between Uninsured (column 1) and Insured (column 2).

Uninsured charges, reported in column 1 include the following, and are multiplied by the CCR to calculate cost:

- Charges for patients without any insurance coverage;
- Charges for patients with coverage from an entity/insurer that does not have a contractual relationship with the provider;
- Charges for patients with insurance coverage, but who were determined uninsured for the hospital stay; and,
- Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs. If such inclusion is specified in the hospital's charity care policy or FAP, and the patient meets the hospital's policy criteria.

Insured charges, reported in column 2, include deductible and coinsurance amounts for insured claims under the following criteria. The cost associated with these charity write-offs is deemed to be the total amount claimed, so the insured amounts are not multiplied by the CCR:

- Amounts here are after payment by an insurer. If insurance did not pay on the claim, the amount should likely be reclassed to the uninsured column 1.
- Traditional Medicare claims should not be included here unless they were not included as Medicare bad debts. For instance, some hospitals may have a presumptive charity clause, and these are not eligible for Medicare bad debt reimbursement but could be reported as charity for S-10 purposes. Otherwise, Medicare bad debts should be included as bad debts instead of charity.
- Medicare Part C amounts can be included here.

Line 22 includes payment received from patients for amounts previously written off as charity care. If amounts in line 20 are net of these payments, this line may be 0.

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). ***This is the amount that CMS uses for each hospital to determine Factor 3 of the uncompensated care payment formula.***

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. At this time, CMS does not use this calculation for anything related to the UCC reimbursement discussed above.

Transmittal 18 Considerations

CMS published significant modifications to the S-10 instructions along with the Transmittal 18 of the 2552-10 regulations. This transmittal was first published on December 22, 2022, and is effective for cost report periods beginning on or after October 1, 2023. The reporting and use have not changed significantly on Worksheet S-10, and the resulting Uncompensated Care calculations used in Medicare DSH payment methodology. However, the requirements for the patient detail supporting the reported amounts have changed significantly.

Detailed listings

Before October 1, 2023, hospitals were required to submit detailed charity care listings to support all amounts claimed on the S-10. These listings were subject to audit, through processes determined by the individual Medicare Administrative Contractors (MACs). There was not a mandated format, so the listings audited were not necessarily consistent amongst MACs and the hospitals in each district.

Starting October 1, 2023, these listings have been standardized as Exhibits 3B "Charity Care Charges" and 3C "Total Bad Debts." The amounts must be submitted in this format and agree to the submitted Worksheet S-10 inputs for cost report acceptance. Samples of these exhibits can be found at Appendix C, with detailed instructions at Appendix B.

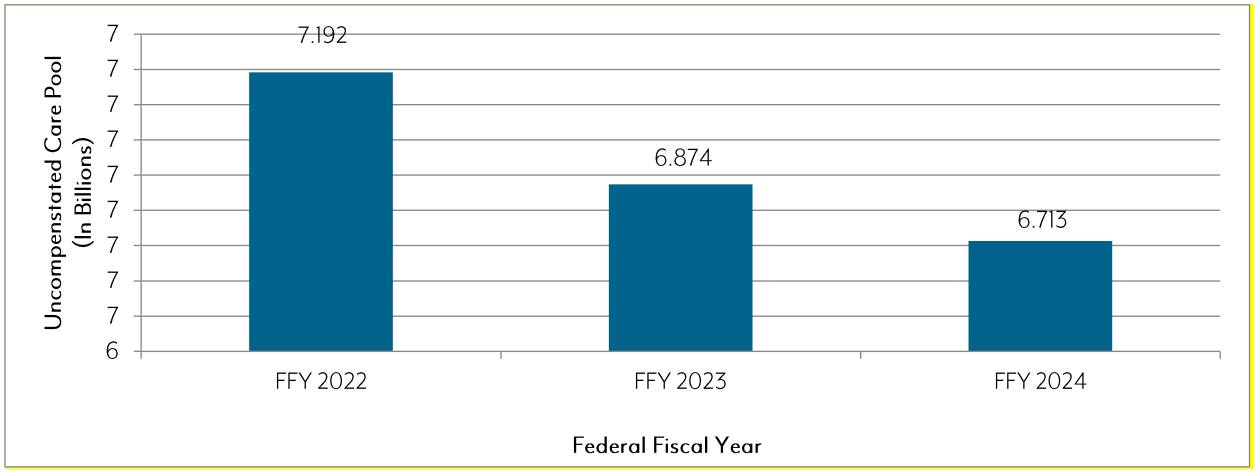
Reporting change

Effective with Transmittal 18, the Worksheet S-10 is now reported as two-parts. Part I contains all entries described above for the entire hospital complex, while Part II contains such entries only for the acute hospital services billable under the hospital's CCN and would exclude any sub-provider units such as Psychiatric Unit, Skilled Nursing Facility (SNF), Home Health (HH), Rural Health Clinics, Swing bed, etc.

Conclusions and Recommendations

The total uncompensated care payment amount proposed for federal fiscal year (FFY) 2024 is approximately $6.7 billion. 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 confirm their data is complete and accurate in anticipation of CMS's reliance on this data to calculate future uncompensated care pool allocations. Hospitals should also be mindful of other organizations analyzing cost report data, who used the cost of charity care reported on Worksheet S-10 to lobby Congress for various regulatory provisions benefitting hospitals.

Graph 1: Total Uncompensated Care Payments Available



Charity care reported on Worksheet S-10 must comply with the hospital's charity care policy. Hospitals should consider all services that qualify as charity care for reporting. 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 charity care is the focus of political advocacy groups rather than bad debt expense.

Appendices

Appendix A: Worksheet S-10 Examples

Example 1

			1.00	
	Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.232515	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		123,989,433	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		618,039,250	6.00
7.00	Medicaid cost (line 1 times line 6)		143,703,396	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		19,713,963	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
	Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		19,713,963	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	116,137,160	1,526,874	117,664,034	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	27,003,632	1,526,874	28,530,506	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	27,003,632	1,526,874	28,530,506	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			93,186,536	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,142,851	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,758,234	27.01
28.00	Non-Medicare bad debt expense (see instructions)			91,428,302	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			21,873,835	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			50,404,341	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			70,118,304	31.00

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Example 2

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.285330	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			8,353,189	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			45,197,525	6.00
7.00	Medicaid cost (line 1 times line 6)			12,896,210	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			4,543,021	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			4,543,021	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	11,105,294	119,162	11,224,456	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,168,674	119,162	3,287,836	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,168,674	119,162	3,287,836	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,514,787	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			166,513	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			256,174	27.01
28.00	Non-Medicare bad debt expense (see instructions)			3,258,613	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,019,441	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			4,307,277	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			8,850,298	31.00

Example 3

			1.00	
	Uncompensated and indigent care cost computation			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.228449	1.00
	Medicaid (see instructions for each line)			
2.00	Net revenue from Medicaid		2,953,882	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		18,005,953	6.00
7.00	Medicaid cost (line 1 times line 6)		4,113,442	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,159,560	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)			
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
	Other state or local government indigent care program (see instructions for each line)			
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)			
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,159,560	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,151,317	1,353,420	4,504,737	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	719,915	1,353,420	2,073,335	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	719,915	1,353,420	2,073,335	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			3,533,480	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			124,705	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			191,854	27.01
28.00	Non-Medicare bad debt expense (see instructions)			3,341,626	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			830,540	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,903,875	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			4,063,435	31.00

Example 4

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.292658	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			3,472,531	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			12,524,069	6.00
7.00	Medicaid cost (line 1 times line 6)			3,665,269	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			192,738	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			192,738	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	1,892,021	413	1,892,434	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	553,715	413	554,128	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	553,715	413	554,128	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			6,103,826	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			76,241	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			117,293	27.01
28.00	Non-Medicare bad debt expense (see instructions)			5,986,533	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			1,793,059	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			2,347,187	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			2,539,925	31.00

Appendix B: CMS Definitions and Instructions

To obtain the most up-to-date version of the cost report instructions, which include the detailed instructions for Worksheet S-10, we recommend going to the CMS Website at www.cms.gov and searching for the Provider Reimbursement Manual, part 2, Chapter 40. This chapter of regulation includes detailed instructions for the completion of the Hospital Cost Report "CMS-2552-10." As new Transmittals are released, the CMS website will update the regulations published on the website.

Appendix C: Transmittal 18 Exhibit 3B and 3C

EXHIBIT 3B

TITLE	CHARITY CARE CHARGES
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
UNINSURED COLUMN 20	0
INSURED COLUMN 20	

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATEINT ACCT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECOND ARY PAYOR	TOTAL CHARGES FOR CLAIM	TOTAL PHYSICIAN/PROFE SSIONAL CHGS	DEDUCTIBLE/COI NSURANCE/COP AY AMOUNTS
1	2	3	4	5	6	7	8	9	10	11

TOTAL THIRD PARTY PAYMENTS	INSURED CONTRACTU AL ALLOWANCE AMOUNT	NONCOVERED CHARGES	TOTAL PATIENT PAYMENTS	AMOUNT WRITTEN OFF AS BAD DEBT	UNINSURED DISCOUNT AMOUNTS	CHARITY CARE NON-COVERED CHARGES	OTHER CHARITY CARE CHARGES	AMOUNTS WRITTEN OFF TO CHARITY CARE AND UNINSURE D DISCOUNTS	WRITE OFF DATE
12	13	14	15	16	17	18	19	20	21

EXHIBIT 3C

TITLE	TOTAL BAD DEBTS
PROVIDER NAME	
HOSPITAL CCN	
COMPONENT CCN	
CRP BEGINNING DATE	
CRP ENDING DATE	
PREPARED BY	
DATE PREPARED	
TOTAL COLUMN 17	0

PATIENT LAST NAME	PATIENT FIRST NAME	DATE OF SERVICE - FROM	DATE OF SERVICE - TO	PATEINT ACCT NUMBER	INSURANCE STATUS	PRIMARY PAYOR	SECONDARY PAYOR
1	2	3	4	5	6	7	8

SERVICE INDICATOR (IP/OP)	TOTAL CHARGES	TOTAL PHYSICIAN/ PROFESSIO NAL CHGS	TOTAL PATIENT PAYMENTS	TOTAL THIRD PARTY PAYMENTS	PATIENT CHARITY CARE AMOUNT	CONTRACT UAL ALLOWANC E /OTHER AMOUNT	A/R WRITE OFF DATE	PATIENT BAD DEBT WRITE OFF AMOUNT
9	10	11	12	13	14	15	16	17

Appendix D: Best Practices

The preparation of the detailed Exhibits supporting the Worksheet S-10 is different for each hospital. However, we have developed some best practices to consider when setting up a process for gathering this data.

1. **Establish a listing of the transactions to include in the detailed listing.** Define the transactions posted during the year that meet the charity or bad debt definitions, and reconcile to the general ledger.
2. **Run Demographic, Charge and Transaction detail files.** These reports will be defined by the patient accounts selected in step 1, and will include the following fields. If it is possible in the hospitals system to run these files out together, that is preferable, but is not generally possible. (Note that *italicized* fields below are not required in Exhibits 3B and 3C, but have been required on audit in the past and likely will be required as identifiers. We recommend including them.)
    a. **Demographic File:** Account Number*, Patient Last Name, Patient First Name, *Social Security Number, Date of Birth, Gender,* Date of Service-from, Date of service-to, Insurance Status, Primary Payor, Secondary Payor, Service Indicator
    b. **Transaction File:** Account Number*, Transaction Code, Transaction Description, Transaction type, posting date
    c. **Charge File:** Account Number*, Revenue Code, Charges
3. **Exhibits Supporting S-10, Part I should be for hospital and subprovider charges, but exclude professional services.** The service indicator on the demographic file or the detail provided in the charge file will help to determine whether the transactions should be on the exhibits. If a patient account has both professional and hospital charges in the same claim, the detail from the charge file will be used to determine a portion of the write off allocated to the hospital.
4. **Exhibits Supporting S-10, Part II should only be for the hospitals' acute hospital charges, not professional or subproviders.**
5. **Transactions will need to be defined between categories defined in the Exhibits.** Some examples might be: Insurance Payments, Insurance Contractual adjustments, self pay payments, charity, uninsured discounts, bad debts. These totals will be accumulated by account number and reported on the Exhibit.
6. **Each line on the Exhibit will represent one unduplicated account number. If there are multiple transactions for a patient, they should be combined and reported on one line.**

7. The resulting totals from these exhibits will be reported on the Worksheet S-10 as detailed in the instructions above

Appendix E: 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 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.