

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 CAHs. *Section 1886(d) hospitals and CAHs* 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--*Consists of* charity care, non-Medicare bad debt, and non-reimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients, *or bad debt reimbursed by Medicare*.

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. *A hospital cannot claim amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt) as charity care amounts.* (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 28.)

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 *42 CFR 413.89(h)* and *CMS Pub. 15-1, chapter 3*. (Additional guidance provided in the instruction for line 28.)

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.)

Public Programs--Federal, State, and/or local government programs paying, in full or in part, for health care (e.g., Medicare, Medicaid, CHIP and/or other Federal, State, or locally operated programs).

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 no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208.

Medicaid

NOTE: The amount on line 18 *must* 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 *Children's Health Insurance Program (CHIP)* 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 *are* 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 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.

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 *CHIP* program. Stand-alone *CHIP* 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 *CHIP* 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 *CHIP* program. These *charges relate* to the services for which payments were reported on line 9.

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

Line 12--Enter the difference between net revenue and costs for stand-alone *CHIP* 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 *CHIP*), 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, *CHIP*, and state and local indigent care programs by entering the sum of lines 8, 12, and 16.

Line 20--

For cost reporting periods beginning prior to October 1, 2016:

Enter the total initial payment obligation, *measured at full charges*, of patients who are given a full or partial discount based on the hospital's charity care criteria for care delivered during this cost reporting period for the entire facility. Include charity care *charges* for all services except physician and other professional services. Do not include charges for *patients given courtesy allowances*. Charges for non-covered services provided to patients eligible for Medicaid or other indigent care programs (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. *Do not include charges of uninsured patients who do not meet the hospital's charity care criteria for a full or partial discount.*

Enter in column 1, the full charges for uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

For cost reporting periods beginning on or after October 1, 2016:

Enter the actual charge amounts for the entire facility, except physician and other professional services that were: (1) determined in accordance with the hospital's charity care criteria/policy, and (2) were written off to charity care during this cost reporting period, regardless of when the services were provided. Do not include charges for patients given courtesy discounts or charges for uninsured patients with or without full or partial discounts who do not meet the hospital's charity care criteria. 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.

Enter in column 1, the total charges, or the portion of the total charges, written off to charity care, for uninsured patients, and patients with coverage from an entity that does not have a contractual relationship with the provider. The portion of total charges is the amount the patient is not responsible for paying (e.g., 100% of charges if the patient qualified for 100% discount or 70% of charges if the patient qualified for a 70% partial discount). Enter in column 2, the deductible and coinsurance payments required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship that were written off to charity care. Do not include in column 2 amounts of deductible and coinsurance claimed as Medicare bad debt.

Line 21--Calculate the cost of *charity care for* patients approved for charity care by multiplying line 1 times line 20. Use column 1 for uninsured patients *and* 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--*For cost reporting periods beginning prior to October 1, 2016*, enter payments received or expected *to be received* from patients who have been approved for 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 *and* 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.

For cost reporting periods beginning on or after October 1, 2016, charity care charges reported on line 20 include amounts written off with no expectation of payment. However, if payment is received during this cost reporting period, regardless of when the services were provided, from patients who have been approved for charity care, enter such payments for the entire facility, except physician or other professional services. Payments from payers should not be included on this line. Use column 1 for uninsured patients and 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 *and* 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 during this cost reporting period on balances owed by patients regardless of the date of service. Include such bad debts for all services except physician and other professional services. *Amounts from line 20 above must not be included here.* 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 January 1, 2011); J-3, line 21; M-3, line 23; *and N-4, line 9.* 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 as adjusted) bad debts as the sum of Worksheets: 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); M-3, line 23 (line 23.01 for cost reporting periods that begin on or after October 1, 2012); *and N-4, line 10.*

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.