Hospital Cost Reports Introduction and Worksheet S

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Agenda

- Why file a Medicare Cost Report?
- Who Uses Medicare Cost Reports?
- What happens after filing a Cost Report?
- Overview of CAH and PPS reimbursement formula
- Worksheet S Series
- Worksheet S-10
  - S-10 New exhibits
  - S-10 Audits

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Why File a Medicare Cost Report?

- Requirement for participation in the Program
- Critical Access Hospitals-Final Reimbursement
- Prospective Payment Providers-Final Reimbursement of bad debts, allied health costs, education costs, disproportionate share, and additional payments for MDHs and SCHs
- Rate Setting-Current and Prospective
- Various exception requests and determinations
- Medicaid implications (vary by state)

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Users of Filed/Settled Cost Reports

- Provider
- Medicare Contractors
- Federal Agencies (CMS, OIG, DOJ, IRS, FBI)
- State Governments
- State and Federal Medicaid Programs
- Competing entities
- Other hospital and non-hospital Providers
- Commercial Payers
  - Note: Filed and Settled Medicare Cost Reports are available under the Freedom of Information Act (FOIA)

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Beyond the Cost Report Other Uses for the Medicare Cost Report

- Provider Use as a Management Tool
- Cost Analysis-Routine and Ancillary Services
- Cost Analysis-Non-Reimbursable Expenses
- Profitability by Cost Center
- Contractual adjustments
- Inpatient Hospital Utilization
- Evaluate Performance
- Financial Modeling
- Identify Opportunities for Improvement
- Comparison to prior year data
- Analysis of Medicare Reimbursement

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The life span of a Cost Report

- Fiscal Year Begins 10/1
- Payment rates based on cost report two years old
- Prior year cost report filed 2/28
- Payment rates updated based on prior year cost report and PSR
- Fiscal Year Ends 9/30
- Cost Report prep starts
- Cost Report Filed 2/28
- May –Tentative settlement issued
- Cost Report Audited by NGS
- Cost Report Audited by State
- Cost Report Final Settled by NGS
- 3 years after final settled date –no re-opening request granted.

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All Cost Reports Are Reviewed by the MAC

- All filed Medicare cost reports are subject to review by the Medicare Administrative Contractor
- May be a desk review or field audit
- Maintain all documentation used in its preparation
- Organize your documentation so that when records are requested, or the audit team arrives, they are readily available
- Prepare your cost report with confidence that it will withstand audit scrutiny
- Wage Index Audit
- Worksheet S-10 audit

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Simplified Cost Reimbursement – Ancillary (Clinics, Therapies, ER, OR, Supplies, Drugs)

Total Allowable Cost	$40,000,000
Total(all payers) GPSR	$86,000,000
Cost to Charge Ratio	46%
Medicare Charges	$22,000,000
Cost to Charge Ratio	46%
Medicare Cost	$10,120,000
Payments	-$11,000,000
Settlement	-$ 880,000

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Simplified Cost Reimbursement – Routine (A+P, ICU, Swing Bed)

Direct Routine Cost	$3,500,000
Less Professional Cost	-$1,000,000
Plus Overhead cost	+$3,000,000
Allowable Routine Cost	$5,500,000
Total Days	2,500
Cost Per Day(per diem)	$2,200
Medicare Days	800
Reimbursement	$1,760,000
Payments	-$1,500,000
Settlement	$260,000

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Basic Medicare Cost Report Mechanics

Worksheet number is at top right-hand corner of each worksheet.

Worksheet Series	
S	Settlement, Organization, and Patient Statistical Information
A	Expense Assignment
B	Allocation of Overhead Costs
C	Patient Care Revenue and Cost-to-Charge Ratio
D	Determination of Medicare's Costs
E	Medicare Settlement and Payment Information
G	Financial Statements
H	Home Health
I	Renal Dialysis
K	Hospice
M	Rural Health Clinic

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Cost Report Schedules

Worksheet S	Worksheet A	Worksheet B	Worksheet C	Worksheet D	Worksheet E
Informational Questions	Expenses	Overhead expense allocation	Charges	Medicare/ Medicaid Charges	Medicare/ Medicaid Settlement
S, S-2, S-3, S-4, S-5, S-7, S-8, S-9, S-10	A, A-6, A-8, A-8-1, A-8-2, A-8-3	B Part I, B-1	C	D Part V, D-3, D-1 Parts I, II, III	E Part B, E-1, E-2 E-3 Part V
Hospital information, patient days, and other statistics	Costs reclassified, added, and subtracted	Overhead allocated to revenue-producing departments	÷ Dept. revenues = Cost-to-charge ratios	X Dept. Medicare charges = Medicare cost	Compared to Medicare Payments = Settlement

Worksheet S Series

Worksheet S	Certification & Settlement
Worksheet S-2 Part I Worksheet S-2 Part II	Identification Data Reimbursement Questionnaire
Worksheet S-3 Part I	Statistical Data
Worksheet S-3 Parts II, III Worksheet S-3 Part IV Worksheet S-3 Part V	Wage Index Information (PPS Hospitals Only) Hospital Wage Related Costs Contract Labor and Benefit Costs (PPS Hospitals Only)
Worksheet S-4	Home Health Agency Statistical Data
Worksheet S-5	Renal Dialysis Statistical Data
Worksheet S-6	CORF Statistical Data & FTEs
Worksheet S-7	PPS SNF Statistical Data
Worksheet S-8	RHC/FQHC Statistical Data
Worksheet S-9	Hospice Identification Data
Worksheet S-10	Uncompensated and Indigent Care Data

Worksheet S

- Part I – Cost Report Status
- Part II – Certification by CFO or administrator or provider(s)
- Part III - Settlement summary
- New Encryption and MCReF
- “The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection.”

Worksheet S

- New Encryption Page

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIV ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by _____{Provider Name(s) and Number(s)} for the cost reporting period beginning _____ and ending _____ and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	**Andrew Smith Michaelson III**	**Y**	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name: **Andrew Smith Michaelson III**			2
3	Signatory Title: **CFO**			3
4	Signature Date: **04/01/2022**			4

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S-2, Part I: Identification Data

- Determines how reimbursement will be calculated for Medicare (Title XVIII) and Medicaid (Title XIX)
- Triggers which worksheets must be completed, examples:
  - Line 105 – Critical Access Hospital → E-3 Part V
  - Line 109 – Therapy services from outside providers → A-8-3
  - Line 140 – Related organizations → A-8-1
  - Line 144 – Hospital-based physicians → A-8-2
- Don't forget to update these inputs:
  - Line 24 – Medicaid days for DSH
  - Line 118.01 – Malpractice premiums and paid losses
  - Lines 167-171 – Meaningful user status

S-2, Part II: Reimbursement Questionnaire

- Must be completed by all hospitals
- Designed to answer questions about key reimbursement concepts and to gather supporting information
- Lines 1 - 21 are required for all hospitals
- Provider Organization and Operation
- Financial Data and Reports
- Approved Education Activities
- Bad Debts
- Bed Compliment
- PS&R Data

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S-2, Part II: Reimbursement Questionnaire

- Lines 22 - 40 are required for cost reimbursed hospitals only
  - Capital Related Cost
  - Interest Expense
  - Purchased Services
  - Provider Based Physicians
  - Home Office Costs
- Lines 41 – 43 are optional to include the cost report preparer contact information

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S-3, Part I: Statistical Data

- Beds in use at the end of the cost report period
- Available bed days adjusted for:
  - Any changes in available beds during the year
  - Leap year
  - CAH hours from Hospital's Health Information System
  - Review to ensure compliance with 96 Hour rule

S-3, Part I: Days/Visits

- Days by Unit and sub-providers
  - Title XVIII (PS&R data), XIX days (S-2 for DSH days), Total (all payers)
  - A+P, Nursery, ICU, rehab, etc.
  - Swing Bed SNF = PS&R Title XVIII days + Medicare Advantage
  - Swing Bed NF = All other Swing Bed days
  - HMO days
  - HOSPICE (non-distinct part)
  - RHC Visits
  - Observation hours converted to days
  - Employee discount days
  - Labor & delivery days

S-3, Part I: Statistical Data

- FTE's
  - Total Interns & Residents
  - Employees On Payroll
- Discharges
  - Less breakout than days
  - A+P make sure to exclude Newborn
  - Rehab

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S-8 RHC/FQHC Statistical Data

- Source of Federal Funds; grants awarded
- Facility hours of operations
- Have you received an approval for an exception to the productivity standard?
  - Increased flexibility with pandemic

S-10: Uncompensated Care & Indigent Care

- Computes indigent care programs shortfall and cost of uncompensated care
  - Uses Hospital cost to charge ratio (CCR)
- Drives reimbursement
  - Uncompensated care payment (UCP) is 75% of total DSH ($6.8 billion)
  - FFY 2023 UCP DSH payments are based on FY 2018 and FY2019 audited S-10
- Medicaid Shortfall
  - Net Medicaid reimbursement
  - Exclude physician and other professional services
  - Medicaid cost = Medicaid charges x CCR

S-10: Uncompensated Care

Definition of Uncompensated Care

- Charity care and uninsured discounts
- Non-Medicare bad debt
- Unreimbursed Medicare bad debt
- Includes all non-professional providers under hospital agreement
- Excludes physicians and professional services
- Excludes Medicaid and Indigent Care program shortfalls

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S-10: Uncompensated Care

Charity Care Charges and Payments

- Line 20 – Charity Care Charges
  - Write-offs in cost report period, regardless of service date
  - Exclude courtesy discounts and charity related to professional fees (physicians and non-physician providers)
  - Column 1 – Uninsured Patients
    - Uninsured or coverage under plan without a contractual relationship with provider
    - Charges patient is not responsible for paying
- Column 2 – Insured Patients
  - Deductible and coinsurance amount
- Line 22 – Charity Care Payments
  - Patient payment for patients included on Line 20

S-10: Uncompensated Care

Total Bad Debts – Line 26

- Total facility bad debts, net of recoveries
- Write-offs in cost report period
- Include gross Medicare bad debts from settlement pages
- Include patient responsibility only
- Exclude amounts due from insurers
- Exclude physician and professional services
- Do not duplicate charity care amounts

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S-10 New Exhibits

- Centers for Medicare & Medicaid Services (CMS) issued transmittal 18 affecting the CMS-2552-10 Hospital Cost Report on December 29, 2022
- These changes are effective for Medicare cost reporting periods beginning on or after October 1, 2022.
- This included two S-10 exhibits, Medicare bad debt exhibit, and DSH exhibit.
- What's new? More fields! If you compare the exhibits to the NGS issued standard request template during the S-10 audit. The number of fields requested is similar in total, but less patient identification fields and more reconciliation.
- New fields: Deductible/coinsurance/copay.
- Special attention will be needed to not duplicate values between columns and to separate write-offs that can span multiple fiscal years.

New S-10 Exhibit 3B Charity Care Charges

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	
INSURED COLUMN 20	

PATIENT CLAIM INFORMATION										
PATIENT NAME - LAST 1	*PATIENT NAME - FIRST* 2	*DATE OF SERVICE - FROM* 3	*DATE OF SERVICE - TO* 4	*PATIENT ACCOUNT NUMBER* 5	*INSURANCE STATUS* 6	*PRIMARY PAYOR* 7	*SECONDARY PAYOR* 8	*TOTAL CHARGES FOR CLAIM* 9	*PHYSICIAN / PROFES-SIONAL CHARGES* 10	*DEDUCT-IBLE / COINSUR / COPAY AMOUNTS* 11

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

New S-10 Exhibit 3C Total Bad Debt

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	

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

SERVICE INDICATOR (IP / OP)	*TOTAL CHARGES*	*TOTAL PHYS-ICIAN / PROFES-SIONAL CHGS*	*TOTAL PATIENT PAYMENTS*	*TOTAL THIRD PARTY PAYMENTS*	*PATIENT CHARITY CARE AMOUNT*	*CONTRACTUAL ALLOWANCE / OTHER AMOUNT*	*A/R WRITE OFF DATE*	*PATIENT BAD DEBT WRITE OFF AMOUNT*
9	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*

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S-10 Audits

What to expect at the start:

- Initial Request Letter, two week deadline
- Excel S-10 Standard Request Template
- HRSA COVID-19 Attestation
- Professional Fees Physician Charges Attestation
- Guide to Worksheet S-10 Audit Submission
- Excel Bad Debt Reconciliation Template

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S-10 Audits Initial Request Letter

1. A copy of the hospital's charity care policy(s) and financial assistance policy(s) (FAP) that was in effect during the cost report period under review.
2. A reconciliation of the bad debts claimed on Worksheet S-10, Lines 20 and 26 to the audited financial statements and/or working trial balance. One starting point can be the AFS supporting working papers for bad debts and charity care. It should list which WTB accounts were used. Also, include written explanation for any variance noted.
3. A detailed listing of the hospital's transaction codes and their descriptions/explanations (e.g. charity and bad debt write-off codes, discount codes, contractual adjustment codes, payment codes.).
4. Detailed query logic describing how the hospital identified patient charges / amounts included in the patient listing used to support charges on Worksheet S-10, Line 20. Please submit the information for each step / process by alpha or numeric order format. Also, we have included detailed guidance on querying the data for Line 20, 22 and 26 to ensure compliance with provider's policies and CMS instructions. See Excel file 'S-10 Standard Data Request Templates.xlsx', tab Questionnaire.
5. Detailed query logic describing how the hospital identified patient payments included in the patient listing used to support payments on Worksheet S-10, Line 22. The specifics to submit the support areidentified in point 4.

S-10 Audits Initial Request Letter (continued)

6. Detailed query logic describing how the hospital identified bad debts included in the patient listing used to support bad debts on Worksheet S-10, Line 26. The specifics to submit the support are identified in point 4.

7. Detail patient listing (see attached Excel template for required detail fields) of charges claimed on Worksheet S-10, Line 20, Columns 1 and 2. Please identify in the patient listing if the listed primary/secondary payor plan is a Medicaid or other indigent care program. See NOTE 1.

8. Detail patient listing (see attached Excel template for required detail fields) of bad debts claimed on Worksheet S-10, Line 26, Column 1. See NOTE 1.

9. Please review and submit the attached HRSA Administered COVID-19 Uninsured Program Payments attestation. In addition, please identify the transaction/payer code(s) that your facility utilizes to record HRSA payments

10. Submit the AFS or the WTB reconciliation to Worksheet C.

11. Detail patient listing (see attached Excel template for required detail fields) of patient payments claimed on Worksheet S-10, Line 22, Columns 1 and 2.(If Applicable)

Any Questions???

Thank you!

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