

**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. Worksheet S-10 provides for the collection of the required data. 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(n)(6)(B) of the Act, as added by section 602 of CAA 2016, adds subsection (d) Puerto Rico hospitals as eligible hospitals under the EHR incentive program. In addition, section 1886(r)(2) of the Act, as added by section 3133 of the ACA, requires an additional payment for uncompensated care for 1886(d) DSH eligible hospitals. Charity care charges, discounts given to uninsured patients that meet the hospital's written financial assistance policy/uninsured discount policy (hereinafter referred to as "financial assistance policy" or FAP), non-Medicare bad debt, and nonreimbursed Medicare bad debt may be used in the calculation of the UCP. CMS does not mandate the eligibility criteria that a hospital uses under its financial assistance policy. Section 1886(d) hospitals and CAHs are required to complete this worksheet.

Worksheet S-10 provides for the collection of uncompensated and indigent care data for the entire hospital complex. Effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10 is Worksheet S-10, Part I; and, effective for cost reporting periods beginning on or after October 1, 2022, Worksheet S-10, Part II, provides for the collection of uncompensated and indigent care data for inpatient and outpatient services billable under the hospital CCN. The data reported on Part II is a subset of the data reported on Part I.

For additional information on uncompensated care and completing the Worksheet S-10, see MLN Matters SE17031 and the CMS Questions and Answers for Worksheet S-10, available on the CMS web site ([cms.gov](https://www.cms.gov)).

**Definitions.--**

**Charity Care and Uninsured Discounts--**Charity care and uninsured discounts result from a hospital's policy to provide all or a portion of medically necessary health care services free of charge to patients who meet the hospital's charity care policy or FAP. Charity care and uninsured discounts can include full or partial discounts. If a patient is not eligible for discounts under the hospital's charity care policy or FAP, then any discounts or reductions given to the standard managed care rate must not be accounted for as charity care or an uninsured discount. Discounts given to patients for prompt payment must not be included as charity care. 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 as charity care amounts of unpaid deductibles and co-insurance for which it has received reimbursement from Medicare (reimbursed Medicare bad debt). (Additional guidance provided in the instruction for line 20.) Hospitals that received HRSA-administered Uninsured Provider Relief Fund (PRF) payments, as authorized by the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Pub. L. 116-136), for services provided to uninsured COVID-19 patients, must not include the patient charges for those services. Under the terms and conditions of the PRF, payments are considered payment in full for such care or treatment.

**Courtesy Allowances--**Courtesy allowances are reductions in charges by a provider in the form of allowances to persons such as physicians, clergy, members of religious orders, and others as may be approved by the governing body of the provider, for services received from the provider. Courtesy allowances also include discounts for prompt payment, friends and family discounts, and employee discounts. Courtesy allowances are not charity care charges, nor are they Medicare bad debts, and must not be included on this worksheet. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs, are not courtesy allowances or charity care and must not be included on this worksheet.

Inferred contractual relationship--For Worksheet S-10 purposes, a contractual relationship between an insurer and a provider will be inferred where a provider accepts an amount from an insurer as payment, or partial payment, on behalf of an insured patient (for example, payments from workman's compensation funds, payments from an automobile insurer for medical benefits, or payments from an insurer for out-of-network services).

Medicare bad debt--When furnishing services to a Medicare beneficiary, a provider incurs costs in furnishing such covered services. A Medicare beneficiary may be responsible for paying a share of those costs as part of their applicable deductible and/or coinsurance amounts. When a Medicare beneficiary, or other responsible party, fails to pay the deductible and/or coinsurance amounts, the provider has incurred costs of furnishing services that are unrecovered. If the unpaid deductible and coinsurance amounts meet the criteria of 42 CFR 413.89, then these amounts may be allowable as Medicare bad debt. Amounts reimbursed as a Medicare bad debt cannot be claimed as charity care.

Non-Medicare bad debt--Charges for health services for which a hospital determines the non-Medicare patient has a financial responsibility to pay, but the non-Medicare patient does not pay. These amounts are subject to the cost-to-charge ratio (CCR). (Additional guidance provided in the instructions for lines 28 and 29.)

Nonreimbursable Medicare bad debt--The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but not reimbursed by Medicare under the requirements of 42 CFR 413.89(h). (Additional guidance provided in the instructions for lines 27 and 27.01.)

Net revenue--Actual payments received or expected to be received from a payer (including coinsurance 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).

Uncompensated care--Consists of charity care and uninsured discounts, non-Medicare bad debt, and nonreimbursable Medicare bad debt. Uncompensated care does not include courtesy allowances, discounts given to patients that do not meet the hospital's charity care policy, or discounts given to uninsured patients that do not meet the hospital's FAP, or bad debt reimbursed by Medicare.

4012.1 Part I - Hospital and Hospital Health Care Complex.--Uncompensated and Indigent Care Cost-to-Charge Ratio--

Line 1--Enter the CCR 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--The amounts reported on lines 2 through 8 are mutually exclusive of the amounts reported on lines 17 and 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 that 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 and/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 and/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 by 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--The amounts reported on lines 9 through 12 are mutually exclusive of the amounts reported on lines 17 and 18.

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 by 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--The amounts reported on lines 13 through 16 are mutually exclusive of the amounts reported on lines 17 and 18.

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 by 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.

Grants, donations and total unreimbursed cost for Medicaid, CHIP, and state/local indigent care--The amounts reported on lines 17 and 18 are mutually exclusive of the amounts reported on lines 2 through 16.

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.

Uncompensated care cost--

Line 20--Enter the charity care charges and uninsured discount amounts determined in accordance with the hospital's charity care criteria/policy or FAP for the cost reporting period as described in A, B, or C. Do not reduce charges in columns 1 or 2 by any payments made for the patient liability (see instructions for line 22 to report payment amounts). All amounts reported on line 20, columns 1 and 2, other than amounts for deductible, coinsurance, or co-payment for hospital services, are subject to the CCR on line 1 when calculating costs on line 21. Do not include in columns 1 or 2:

- amounts that do not meet the hospital's charity care policy or FAP;
- Medicaid shortfalls, contractual allowances, or amounts for patients given courtesy allowances;
- deductible and coinsurance amounts claimed as Medicare bad debts;
- charges for physician and other professional services; and
- charges reported in a previous cost reporting period.

Effective for cost reporting periods beginning on or after October 1, 2018, a cost report is rejected when submitted without listings supporting the charity care amounts claimed on line 20 (42 CFR 413.24(f)(5)). Exhibit 3B presents the standard format for the information required to support the charity care amounts claimed and must be submitted with cost reports for periods beginning on or after October 1, 2022. (See exhibit and instructions presented at the end of §4012.7.)

A. For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) for cost reporting periods beginning on or after October 1, 2016, enter the total initial payment obligation, measured at full charges, for patients, including uninsured patients, who are given a full or partial discount based on the hospital's charity care policy or FAP for medically necessary health care services delivered during this cost reporting period for the entire facility.

Column 1 (Uninsured Patients): Enter the sum of charges for:

- uninsured patients; and
- patients with coverage from an entity/insurer that does not have a contractual relationship with the provider; and
- insured patients that were determined uninsured for the entire hospital stay; and
- 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.

Column 2 (Insured Patients): Enter the sum of:

- amounts for deductible and coinsurance 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; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by 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 (such amounts must also be included on line 25).

Column 3: Enter the sum of columns 1 and 2.

B. For cost reporting periods beginning on or after October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) beginning on or after October 1, 2020, through cost reporting periods beginning prior to October 1, 2022, enter the actual charge amounts for the entire facility for patients, including uninsured patients who were given full or partial discounts that were determined in accordance with the hospital's charity care criteria/policy or FAP, and written off during this cost reporting period, regardless of when the services were provided.

Column 1 (Uninsured Patients): Enter the sum of:

- total charges, or the portion of the total charges for uninsured patients; and
- total charges, or the portion of total charges for patients with coverage from an entity/insurer that does not have a contractual relationship with the provider; and
- total charges, or the portion of total charges for insured patients that were determined uninsured for the entire 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.

**NOTE FOR COLUMN 1:** The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100 percent of charges if the patient qualified for 100 percent discount or 70 percent of charges if the patient qualified for a 70 percent discount).

Column 2 (Insured Patients): Enter the sum of amounts written off to charity care for:

- deductible and coinsurance required by the payer for insured patients covered by a public program or private insurer with which the provider has a contractual relationship; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by 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 (such amounts must also be included on line 25).

Column 3: Enter the sum of columns 1 and 2.

C. For cost reporting periods beginning on or after October 1, 2022, including subsection (d) Puerto Rico hospitals under §1886(n)(6)(B), enter the actual charges for the entire facility for patients, including uninsured patients, who were given full or partial discounts that were written off during this cost reporting period, regardless of when the services were provided.

Column 1 (Uninsured Patients): Enter amounts written off to charity care for:

- total charges, or the portion of total charges, for uninsured patients; and
- total charges, or the portion of total charges, for patients with coverage from an entity/insurer that does not have a contractual or inferred contractual relationship with the provider; and
- total charges, or the portion of total charges, for insured patients that were determined uninsured for the entire 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.

**NOTE FOR COLUMN 1:** The total charges or the portion of total charges is the amount the patient is not responsible for paying (e.g., 100 percent of charges if the patient qualified for 100 percent discount or 70 percent of charges if the patient qualified for a 70 percent partial discount).

Column 2 (Insured Patients): Enter amounts written off to charity care for:

- deductible, coinsurance, and co-payment amounts for hospital services required by the payor for insured patients covered by a public program or private insurer with which the provider has a contractual or inferred contractual relationship; and
- non-covered charges for days exceeding a length-of-stay limit for patients covered by 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 (such amounts are subject to the CCR and must be included on line 25); and
- charges, or the portion of charges, other than deductible, coinsurance, and co-payment amounts that represent the insured patient's liability for medically necessary hospital services (such amounts are subject to the CCR, and must be included on line 25.01). These charges include a patient's liability from a contractual or inferred contractual relationship between a public program or private insurer and the provider.

Column 3: Enter the sum of columns 1 and 2.

Line 21--Calculate the cost for charity care and uninsured discounts. In column 1, calculate the cost of uninsured patients approved for charity care and uninsured discounts by multiplying line 20, column 1, by the CCR on line 1. In column 2, calculate the cost of insured patients approved for charity care in accordance with A or B. In column 3, enter the sum of columns 1 and 2.

- A. For cost reporting periods beginning prior to October 1, 2022: enter the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus line 25) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit that are subject to the CCR on line 1 (line 25 multiplied by line 1).
- B. For cost reporting periods beginning on or after October 1, 2022, enter the sum of the deductibles and coinsurance not subject to the CCR on line 1 for insured patients approved for charity care (line 20, column 2, minus lines 25 and 25.01) plus the non-covered charges for insured patients for days exceeding a length-of-stay limit and charges for insured patients' liability that are subject to the CCR on line 1 (lines 25 and 25.01, multiplied by line 1).

Line 22--Enter payments received from patients for amounts previously written off as charity care. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. Do not include:

- payments from payers;
- grants or other mechanisms of funding for charity care;
- payments for physician or other professional services; and
- payments received that represent a patient's liability, or amounts that were not previously written off on line 20 as charity care or uninsured discounts.

A. For cost reporting periods beginning prior to October 1, 2016, and for subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) beginning on or after October 1, 2016, enter the sum of payments received and payments expected to be received for the entire facility from patients who have been approved for charity care or uninsured discounts for health care services delivered during this cost reporting period. In column 1, enter payments from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. In column 2, enter payments from patients covered by a public program or private insurer with which the provider has a contractual relationship. In column 3, enter the sum of columns 1 and 2.

B. For cost reporting periods beginning on or after October 1, 2016, (except subsection (d) Puerto Rico hospitals under §1886(n)(6)(B) as those hospitals continue to follow the instructions in A), through cost reporting periods beginning prior to October 1, 2022, enter all payments for the entire facility received from patients during this cost reporting period, regardless of when the services were provided, for amounts previously written off on line 20 as charity care or uninsured discounts. In column 1, enter payments received from uninsured patients and patients with coverage from an entity that does not have a contractual relationship with the provider. In column 2, enter payments received from patients covered by a public program or a private insurer with which the provider has a contractual relationship. In column 3, enter the sum of columns 1 and 2.

C. For cost reporting periods beginning on or after October 1, 2022, enter the sum of payments received from patients during this cost reporting period for the entire facility for amounts previously written off on line 20 as charity care or uninsured discounts. In column 1, enter payments received from uninsured patients and patients with coverage from an entity that does not have a contractual or inferred contractual relationship with the provider. In column 2, enter payments received from patients covered by a public program or a private insurer with which the provider has a contractual or inferred contractual relationship. Payments entered on this line must not exceed charity care or uninsured discount amounts written off in the cost reporting period. In column 3, enter the sum of columns 1 and 2.

Line 23--Calculate the cost of charity care for columns 1 and 2 by subtracting line 22 from line 21. In column 1, enter the cost for uninsured patients and patients with coverage from an entity that does not have a contractual relationship (or an inferred contractual relationship for cost reporting periods beginning on or after October 1, 2022) with the provider. In column 2, enter the cost for patients covered by a public program or private insurer with which the provider has a contractual relationship (or an inferred contractual relationship for cost reporting periods beginning on or after October 1, 2022). For columns 1 and 2, if the amount on line 22 is greater than line 21, enter zero. In column 3, enter the sum of columns 1 and 2.

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 on 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, if such inclusion is specified in the hospital's charity care policy or FAP and the patient meets the hospital's policy criteria, for services delivered during this cost reporting period. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.

Line 25.01--For cost reporting periods beginning on or after October 1, 2022, enter the charges that represent the insured patient's liability for medically necessary hospital services, other than deductible, coinsurance, and co-payment amounts. The charges entered on this line are subject to the CCR and must also be reported in the amount on line 20, column 2.



Line 26--For cost reporting periods beginning prior to October 1, 2022, enter the amount of bad debts (Medicare bad debts and non-Medicare bad debts), net of recoveries, written off during this cost reporting period on balances owed by patients for the entire facility regardless of the date of service. Do not include:

- bad debts for physician and other professional services; and
- amounts from line 20; and
- amounts for privately insured patients that were the obligation of an insurer rather than the patient.

For cost reporting periods beginning on or after October 1, 2022, enter the amount of Medicare and non-Medicare bad debts/implicit price concessions (pursuant to the Accounting Standards Update, Topic 606) written off during this cost reporting period, net of recoveries, that relate to balances owed by patients, regardless of the date of service, for the entire facility. Submit Exhibit 3C to support the bad debt amount claimed. Do not include:

- bad debts for physician and other professional services; and
- amounts from line 20; and
- amounts for privately insured patients that were the obligation of an insurer rather than the patient.

Line 27--Enter the Medicare reimbursable (also referred to as adjusted) bad debts, for the entire facility, including PARHM demonstration, pursuant to 42 CFR 413.89(h). The amount must be the sum of the amounts reported on 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; H-4, line 27.01, column 2; 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 27.01-- Enter the Medicare allowable bad debts, for the entire facility, including PARHM demonstration. The amount must be the sum of 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; H-4, line 27, column 2; I-5, line 5.05, column 2; J-3, line 21; M-3, line 23; and N-4, line 9.

Line 28--For cost reporting periods beginning before October 1, 2013, calculate the non-Medicare bad debt amount by subtracting line 27 from line 26. For cost reporting periods beginning on or after October 1, 2013, calculate the non-Medicare bad debt amount by subtracting line 27.01 from line 26.

Line 29--Calculate the non-Medicare and nonreimbursable Medicare bad debt amount.

A. For cost reporting periods beginning before October 1, 2013, calculate the non-Medicare and nonreimbursable Medicare bad debt amount by multiplying line 28 by the CCR on line 1.

B. For cost reporting periods beginning on or after October 1, 2013, calculate the non-Medicare and nonreimbursable Medicare bad debt amount as the sum of:

- non-Medicare bad debt amount on line 28 multiplied by the CCR on line 1, plus
- nonreimbursable Medicare bad debt amount calculated by subtracting line 27 from line 27.01 (this amount is not multiplied by the CCR on line 1).

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

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