Medicare DSH
Dissecting Uncompensated Care Cost

September 17, 2018
Uncompensated Care Update

Primary Focus of this Presentation

- To provide hospitals a document to assist with the filing of uncompensated care (UC) cost on Medicare cost report worksheet S-10 (line 30).
- Other worksheet S-10 information (i.e., Medicaid shortfalls), that is not used in the determination of UC cost and Medicare disproportionate share (DSH) UC payment is not discussed in this document.
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Section 1

Background

The Significance of Reporting Uncompensated Care (UC)
Medicare DSH UC Payments for FFY 2019

- $8.3B of national UC payments for Federal Fiscal Year (FFY) 2019.
- FFY 2019 will be the second year worksheet S-10 is used to determine hospital UC payments, now as 2/3 of “factor 3” (factor 3 represents each hospital’s percentage of national UC DSH funding).
Section 1: Background

FFY 2019 "Factor 3" for Medicare UC DSH

2013 Medicaid Days + 2016 SSI Days

2014 UC Cost (S-10 Line 30 Under Transmittal 11)

2015 UC Cost (S-10 Line 30 Under Transmittal 11)

*2014 Cost Reports*: cost reporting periods beginning during FFY 2014 (10/1/13 – 9/30/14).

Section 1: Background

CMS Transmittal 11 – Uncompensated Care
Comprehension is Key Prior to Reporting

**Includes**: Charity care*, non-Medicare bad debt, and non-reimbursable Medicare bad debt.

**Excludes**: Courtesy allowances (including prompt pay discounts)**, 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 financial assistance policy (FAP), or bad debt reimbursed by Medicare.

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*If specified in the FAP and the discount procedure is followed, charity also includes self-pay discounts, non-covered charges to Medicaid eligible patients and charges related to an insured patient with a carrier not under contract with the hospital.

**CMS characterizes “courtesy” as discounts for prompt pay, friends and family, etc. Policies using the term “courtesy” should evaluate either changing the terminology or defining the terminology in the policy as charity care.
Section 1: Background

- Uninsured and Charity Care
- Non-Reimbursable Medicare Bad Debt
- Medicaid or Other Indigent Care Program Non-Covered Charges*
- Non-MCR Bad Debt
- Non-Covered Services to Medicaid Eligible Patients or Other Indigent Care Carriers

- Each category must follow CMS’ instruction to qualify for reporting as UC on WS S-10. **Comprehension of the instructions is imperative.**
- These instructions indicate changes hospitals can consider when crafting charity care policies, FAPs and establishing transaction codes.

*Related to days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care programs.
Section 1: Background

Major Change in Transmittal 11 Cost Reporting Instructions

Transmittal 11 updated the definition of charity care.

Charity Care now includes all patients receiving financial assistance*.

This consists of not only charity care patients, but also patients receiving self pay discounts.

*All reported amounts must be specified in the hospital’s financial assistance policy and the patient must meet the policy criteria. Courtesy discounts (i.e., friends and family) and prompt pay are not allowable for reporting as charity care.
Section 1: Background

CRs Beginning Before 10/1/16
- Charity based on full hospital charges and date of service.
- Bad Debt based on write-off amount and write-off date.

CRs Beginning On/After 10/1/16
- Charity based on hospital charges written-off amount and write-off date.
- Bad Debt based on write-off date.

New reporting requirement for cost reports beginning on or after 10/1/18:
- Hospitals must include a detailed listing of charity care and/or uninsured discounts reconciling to the amount claimed in the hospital’s cost report (WS S-10).
- CMS cites including information such as patient name, dates of service, insurer (if applicable), and the amount of charity care and/or uninsured discount.
Uncompensated Care Update

Section 2

Financial Assistance Policies

Policy Language Determines Uncompensated Care Reporting
Section 2: Financial Assistance Policies

IRC Section 501(r)
- UC amounts depend on financial assistance policy.
- Reported as “Financial Assistance” on Schedule H of Form 990.

Medicare Cost Report
- UC amounts depend on financial assistance policy.
- Reported on worksheet S-10 of the Medicare Cost Report.

Uncompensated care is also recorded on financial statements, community benefit reports, state government reports and Medicaid DSH Surveys.
Section 2: Financial Assistance Policies

- Ensure FAPs/charity care policies clearly state how discounts are applied to uninsured patients and insured patients.
- Determine if these policies cover hospital services vs. non-allowable professional services (physicians).
  - Referencing the hospital’s compliance with a state law requiring financial assistance to uninsured patients helps solidify the FAP language.
  - However, per CMS’ FAQs “The state regulation may be cited, however, the hospital’s written charity care policy or FAP must also include its state law requirement regarding discounts that are automatically applied.”
  - **Important as coinsurance and deductibles are not reduced by the CCR.**
  - **Tip:** Consider reviewing charity coinsurance and deductible (C+D) amounts ending up as bad debt (reduced by CCR) in relation to the hospital’s policy. Uncollectable C+D recognized as charity is not reduced by the CCR.
  - **Hospitals may define this term differently than CMS.**
- Identify whether the hospital is using the term “courtesy” synonymously with charity care. Policies using the term “courtesy” should evaluate either changing the terminology or defining the terminology in the policy as charity care.
Section 2: Financial Assistance Policies

Presumptive Eligibility

- **Tip:** Include language of presumptive eligibility (PARO), and ensure the hospital’s FAP reflects the procedure for qualifying patients for presumptive aide.

Insured Patients Not in Contract with Hospital

- **Tip:** Include if and how financial assistance is available for insured patients and is deemed as “charity”, when an insurance carrier is not under contract with the hospital or when a commercial carrier denies a claim.

Non-Covered Medicaid (or other indigent program)

- **Tip:** Specify if and how non-covered services are determined as charity for Medicaid eligible patients (or other indigent care program).
- **Tip:** When reporting non-covered Medicaid services, ensure amount reported as charity care reflects the non-covered charges (as opposed to the amount not reimbursed by Medicaid).
- **Tip:** Define what is included as a “non-covered” service for Medicaid eligible patients.
- **Tip:** Non-covered Medicaid can be identified by reviewing transaction detail or by reviewing zero balance accounts with no insurance payment.
Section 2: Financial Assistance Policies

Examples of Further Clarification from CMS Regarding FAPs and UC Reporting

Presumptive Eligibility
• Is there ideal presumptive eligibility language that hospitals should include their FAPs?

Definition of Non-Covered
• What is the definition of “specified” regarding non-covered Medicaid services in a hospital’s FAP?
• CMS does not define “non-covered” services in S-10 instructions. No current S-10 distinction between non-covered and non-billable (denials).

Non-Contractual Relationship
• Why is this UC category separate from natural charity care qualification?
• If charges related to patients with insurance not under contract with the hospital may be reported, can hospitals also report charges related to non-covered services provided to insured patients? What is the difference in terms of uncompensated care?
Uncompensated Care Update

Section 3

Charity Care and Uninsured Discounts

Comprehension of Instructions and Keys to Reporting Cost
Section 3: Charity Care and Uninsured Discounts

Categories for Charity Care and Uninsured Discounts (Line 20)
Charity Care / Uninsured Discounts / Non-Covered Services for Medicaid Eligible Patients / Patients Not Under Contract with Hospital*

- Includes full and partial charge discounts for insured and uninsured patients.
- Charity C+D are reported separately in col 2 (not reduced by CCR).**
  - **Tip:** Sample large C+D amounts (i.e., >$30K) to insure they are not related to other transaction (i.e., insurance denials).
  - **Tip:** Filter C+D by payer to ensure no amounts are reported for self-pay or Medicaid patients.
  - **Tip:** Remove Medicare charity C+D amounts if they are reported on line 20 col 2 and as bad debt on line 26.

*Amounts can only be reported on WS S-10 if specified in the charity care policy or FAP and the patient meets the policy criteria.*

**Charges related to Medicaid days (or days from other indigent care program) exceeding a length of stay limit are also reported on this line and line 25 to insure these amounts are reduced by the CCR.
Section 3: Charity Care and Uninsured Discounts

Categories for Charity Care and Uninsured Discounts (Line 20)
Charity Care / Uninsured Discounts / Non-Covered Services for Medicaid Eligible Patients / Patients Not Under Contract with Hospital*

- In the FFY 2019 Final Rule CMS states:
  - “Nothing prohibits a hospital from considering a patient’s insurance status as a criterion in its charity care policy. A hospital determines its own financial criteria as part of its charity policy.”
- In the S-10 FAQs, CMS responds that charity for insured patients - whereby the charity is not the patient’s coinsurance/deductible - cannot be reported on WS S-10 Line 20, Col 2 (no mention of Col 1).
- **Insight:** The FFY 2019 Final Rule and FAQ language may help support hospitals accurately capture UC related to all accounts considered in the FAP to be uninsured.

*Amounts can only be reported on WS S-10 if specified in the charity care policy or FAP and the patient meets the policy criteria.*
Section 3: Charity Care and Uninsured Discounts

Patient Payments (Line 22)

Cost Reports Beginning Prior to 10/1/16

• Payments received or expected to be received from patients who have been approved for charity care or uninsured discounts for healthcare services delivered during the cost reporting period.
  • Column 1 for uninsured patients (associated charges reported on L 20, Col 1).
  • Column 2 for insured patients (associated amounts reported on L 20, Col 2).

Cost Reports Beginning On/After 10/1/16

• Payments received during this cost reporting period, regardless of when the services were provided, from patients for amounts previously written off on line 20 as charity care or uninsured discounts.
  • Because charity care and self-pay discounts are now reported by write-off, there is no expectation of patient payment.
  • CMS requires providers to report patient payments, even if the charity discount was provided and recorded in a prior year.

*Do not include payments for physician or other professional services.

• Tip: For cost reports beginning during and after 10/1/16, it is recommended hospitals establish a system to recognize payments received related to a prior cost that was or was not recorded on a prior year cost report.
  o If the cost was not recorded on a prior year cost report, then the patient payments should not be reported.
  o If the cost was recorded on a prior year cost report, then the patient payment should be reported.
Section 3: Charity Care and Uninsured Discounts

Cost Reports Beginning Before 10/1/16

<table>
<thead>
<tr>
<th>Scenario 1: Reporting Actual Payments Received</th>
<th>Scenario 2: Reporting Expected Payments Received</th>
<th>Ref.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Charity and Uninsured Amounts (Lines 20-23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Total Hospital Charges on Line 20</td>
<td>10,000</td>
<td></td>
</tr>
<tr>
<td>B. Uninsured Cost on Line 21 (A*20% CCR)</td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td>C. Payment on Line 22</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>D. Uninsured Cost on Line 23 (B-C)</td>
<td>2,000</td>
<td></td>
</tr>
<tr>
<td>E. Cost % of the Total Charity Care Charges (D/A)</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>II. Bad Debt Amounts (Line 26 and Line 29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Bad Debt on Line 26</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>G. Bad Debt Cost to Line 29 (F*20% CCR)</td>
<td>0</td>
<td>200</td>
</tr>
<tr>
<td>H. Bad Debt Cost as % of Bad Debt Charges (G/F)</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>III. Total Amounts Reported on WS S-10 (Line 30)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Grand Total Amount of UC Cost (D+G)</td>
<td>2,000</td>
<td>1,200</td>
</tr>
<tr>
<td>J. Recognized Percentage of UC Cost (I/A)</td>
<td>20%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Ref. 1: “Enter payments received or expected to be received from patients who have been approved for charity care or uninsured discounts for healthcare services delivered during this cost reporting period.”
Ref. 2: If the patient balance remains unpaid and the hospital determines it to be a bad debt, it can be recorded as a hospital bad debt on line 26 (per MLN matters example 5).
Uncompensated Care Update

Section 4

Bad Debt

Comprehension of Instructions and Keys to Report Hospital Cost
Section 4: Bad Debt

**Includes:** Medicare bad debts and non-Medicare bad debts - net of recoveries.

**Excludes:** Amounts related to professional services (physicians) and any amounts already reported on WS S-10 line 20.

**Insight:** Medicare FFS allowable bad debts must be included in the total, as these amounts are automatically deducted from the total and treated separately in the calculation of UC cost.

**Insight:** In the S-10 FAQ, regarding the definition of “write-off”, CMS refers to Medicare rules stating, “If a hospital writes off bad debt in a general ledger and continues collection, Medicare would not recognize this as a Medicare bad debt. The amount reported for all other non-Medicare bad debts must be net of recovery.”
Section 4: Bad Debt

Not All Bad Debts are Treated Equal

Co-ins and Deductibles from Insured Patients Determined as Charity Care
Line 20
Col 2
No CCR Reduction

Co-ins and Deductibles from Non-reimbursable Medicare Bad Debts
Line 29
No CCR Reduction

Co-ins and Deductibles from Insured Patients Not Eligible for Charity Care
Line 26
CCR Reduction
Section 4: Bad Debt

FASB Topic 606 on Revenue Recognition

Intent
Consistency in reporting revenue across industries

Effective Date
Fiscal Periods Beginning After 12/15/17

Impact on Financials
Hospital reporting of bad debt will decrease

Impact on WS S-10
CMS clarification may be needed for reporting consistency

- Focus is on implied performance obligations.
  - "A performance obligation can be explicit in a contract or it can be implied."
- Amounts not historically collected are considered an implicit promise of service (implicit price concession).*

- Hospitals may reclassify amounts previously written off as bad debt to charity.
- This may involve determining the likelihood of collecting on accounts.
- Amounts historically not collected would then be deemed charity for UC reporting.

*FASB Topic 606 at [https://asc.fasb.org/imageRoot/32/79982032.pdf](https://asc.fasb.org/imageRoot/32/79982032.pdf). Refer to example 12, Case B “Implicit Promise of Service” on implicit price concessions.
Section 5

Working with UC Data

S-10 Reporting and Preparing for Audit
# Section 5: Working with UC Data

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transaction Code Report - Charity Care, Uninsured Discounts and Bad Debt</td>
<td>To determine the transaction codes and appropriate amounts to report for accounts with charity care, uninsured discounts, non-covered services to Medicaid eligible patients (included services exceeding a Medicaid LOS limit), and bad debt.</td>
</tr>
<tr>
<td>Hospital Policies: Financial Assistance, Charity Care and Bad Debt</td>
<td>To identify allowable uncompensated care amounts and determine which transaction codes (above) match each FAP category.</td>
</tr>
<tr>
<td>Patient A/R Detail</td>
<td>To report charges and payments associated with transaction codes allowable for UC cost reporting. Also use the A/R detail to ensure amounts are not double counted as charity care and bad debt (especially for cost reported beginning before 10/1/16, as charity care is reported at full hospital charges).</td>
</tr>
<tr>
<td>Listing of Non-Contracted Insurance Plans</td>
<td>To determine potential claims eligible as uncompensated care whereby the entity does not have a contractual relationship with the provider.</td>
</tr>
</tbody>
</table>
## Section 5: Working with UC Data

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bad Debt</td>
<td>To understand the accounting of hospital bad debts, specifically when/how accounts are written off as bad debt. Prior MAC audit of bad debts should be considered.</td>
</tr>
<tr>
<td>Detailed listing of Medicare Bad Debt log for the respective cost reporting years</td>
<td>To ensure the Medicare bad debts reported on the cost report are included in the amount of total bad debts reported by the hospital on line 26.</td>
</tr>
</tbody>
</table>
| Sample of Accounts Reported on WS S-10                                      | To sample and test accounts for audit support. Account support may include, but is not limited to:  
  o Patient A/R Detail  
  o Completed patient eligibility forms for FAP/charity care  
  o Notes on patient account  
  o Hospital support of bad debt including collection agency notes                                                                                                                                  |
Section 5: Working with UC Data

- Identify Account Types
- Summarize Data
- Support Determined UC Amounts


Identify Hospital Policy Definitions
Sample Claims for Appropriateness of Reporting

Going forward and reporting for future years...
collaborate and discuss what processes can be improved to better capture UC data.
For instance, changes to FAP language and establishing new transaction codes tailored to the various “buckets” of uncompensated care.
Section 5: Working with UC Data

Key Takeaways

- Working with **IT** on A/R queries will help reduce time. The data is LARGE.
- Collaborating on the policy language with **PFS and FAP experts** is an integral part of understanding data for S-10 reporting.
- Using **transaction codes** that correspond with the hospital’s FAP provides comprehensive support.

Sampling Claims

For every claim there is a different story.
Be prepared to understand different encounter types and transactions.
Ensure the hospital is following its policy with procedure.
Employ routine control measures on policy and claim processing.
Include large dollar amounts in the sample.
Section 5: Working with UC Data

Notable MAC S-10 Audit Requests (Sept. 2018)

- “Describe the logic and process used when querying the hospital charge listings to identify the charges to report on line 20 of worksheet S-10 of the cost report.”
- “If contractual transaction/adjustment codes are used in this listing, please provide an index to these codes, with a description of what each code means.”
- “A reconciliation of the bad debt write-offs from your financial accounting records to bad debts reported on line 26 of worksheet S-10 of the cost report.”

Requested Charity Care Fields

- Claim type (insured or uninsured)
- Primary payor plan
- Secondary payor plan
- Hospital's Medicare Number
- Patient identification number (PCN)
- Patient's date of birth
- Patient’s social security number
- Patient’s gender
- Patient name
- Admit date
- Discharge date
- Service indicator (hospital inpatient or outpatient)
- Revenue code
- Revenue code total charges for the claim
- Date of write off to charity care
- All patient payments received or expected to be received
- All third-party payments received or expected to be received
- Patient charity contractual amount by transaction/adjustment code
- Other contractual amount by transaction/adjustment code (insurance write-off, courtesy discounts, etc.)
- Non-covered charges for days exceeding a length-of-stay limit for patients covered by Medicaid or other indigent care
Section 6

HCRIS Analysis

Data Verifies Reporting Can Improve
Section 6: HCRIS Analysis

❖ To evaluate the dependability of HCRIS Uncompensated Care (UC) data reported on Medicare cost report WS S-10*.

❖ UC cost was calculated from FFY 2014 and FFY 2015 cost reports per the September 2017, March 2018 and June 2018 HCRIS.

❖ WS S-10 revisions between the September and June HCRIS:
  ➢ FFY 2014 Cost Reports – 1,591 DSH hospitals (68%)
  ➢ FFY 2015 Cost Reports – 1,851 DSH hospitals (79%)

❖ September 30, 2017: Cost report HCRIS data representing unadjusted “as filed” uncompensated care (before hospital revisions).


❖ June 30, 2018: CMS HCRIS data used in the in development of the FFY 2019 IPPS Final Rule (CMS initially planned on using data from the March 31, 2017 HCRIS in development of the Final Rule).

*This analysis excludes the cost report trim, UC data for non-DSH hospitals (according to the FFY 2019 Proposed Rule Final Rule), All Inclusive Rate Providers (AIRP), Maryland hospitals Puerto Rico hospitals, and Indian Health Services (IHS)/Tribal hospitals.
Section 6: HCRIS Analysis

Largest Issue

- Approximately 20% of DSH hospitals are reporting charity coinsurance and deductibles (C+D) more than 25% of total charity care charges.
  - The national average is ~6%.
  - Over half the hospitals identified as over-reporting C+D submitted UC cost changes by the June HCRIS.
  - CMS sent letters to some hospitals requesting them to verify or amend C+D by April 20, 2018.

- Why is this important? New CMS instructions under T11 no longer reduce charity C+D by the CCR. Any amounts, incorrectly reported as C+D, will result in an overstatement of total UC cost.

Charity Coinsurance and Deductibles Greater Than 25% of Charity Charges

According to the June HCRIS file, for FY 2016 cost reports, there are 552 hospitals with charity care C+D above 25% of total charity care charges.

Section 6: HCRIS Analysis

Prior Charity Cost Calculation
Hypothetical Hospital Data

- In this example, the hospital reported charity C+D at $30M (key “C” below).
- Prior to T11, the $30M was reduced by the CCR (to $6M), resulting in $25M of charity cost.

<table>
<thead>
<tr>
<th>Line Number and Description</th>
<th>Col 1: Uninsured Patients</th>
<th>Col 2: Insured Patients</th>
<th>Col 3: Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to Charge Ratio</td>
<td>20% (A)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Line 20: Charity care charges and uninsured discounts</td>
<td>$100,000,000 (B)</td>
<td>$30,000,000 (C)</td>
<td>$130,000,000 (D = B+C)</td>
</tr>
<tr>
<td>Line 21: Cost of patients approved for charity care and uninsured discounts</td>
<td>$20,000,000 (E = A*B)</td>
<td>$6,000,000 (F = A*C)</td>
<td>$26,000,000 (G = E+F)</td>
</tr>
<tr>
<td>Line 22: Payments received from patients for amounts previously written off as charity care</td>
<td>$1,000,000 (H)</td>
<td>$0 (I)</td>
<td>$1,000,000 (J = H+I)</td>
</tr>
<tr>
<td>Line 23: Cost of charity care (line 21 minus line 22)</td>
<td>$19,000,000 (K = E-H)</td>
<td>$6,000,000 (L = F-I)</td>
<td>$25,000,000 (M = K+L)</td>
</tr>
</tbody>
</table>
Section 6: HCRIS Analysis

New Charity Cost Calculation
Using Same Hypothetical Hospital Data

- In this example, the hospital reports the same exact data (including the C+D at $30M in key “C”).
- Under T11, the $30M is not reduced by the CCR, resulting in $49M of cost ($24M>T10 amount).
- Any amounts reported as part of the $30M – that are not related to charity C+D – will overstate cost.

<table>
<thead>
<tr>
<th>Line Number and Description</th>
<th>Col 1: Uninsured Patients</th>
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<tr>
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<td>$19,000,000 (K = E-H)</td>
<td>$30,000,000 (L = F-I)</td>
<td>$49,000,000 (M = K+L)</td>
</tr>
</tbody>
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# CMS S-10 Resources

<table>
<thead>
<tr>
<th>Source</th>
<th>Link</th>
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<tbody>
<tr>
<td>CMS Worksheet S-10 FAQs</td>
<td><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Worksheet-S-10-UCC-QandAs.pdf">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/Worksheet-S-10-UCC-QandAs.pdf</a></td>
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</table>
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