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Chad Krcil, FHFMA

- 31+ years of health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Reimbursement optimization strategies
  - Third party reimbursement audit and review and due diligence analysis
- BDO USA, P.A.
  - The BDO Center for Healthcare Excellence & Innovation
  - Healthcare Reimbursement, Reporting and Compliance
  - Managing Director, Healthcare Advisory
- HFMA
  - Colorado Chapter
  - Region 10 Region Executive Team (FY 2020-2024)
  - President (FY 2018/2019) (FY2019/2020)
  - President-Elect (FY 2017/2018)
  - VP of Education (FY 2016/2017)
  - Chapter Secretary (FY 2015/2016)
  - Certified Healthcare Financial Professional
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Agenda for Today

1. Revenue Cycle Collaboration
2. Uses for the Medicare Cost Report
3. Medicare Cost Report
4. Key Drivers of Medicare Reimbursement
5. Medicare Cost Report KPI & Benchmarking

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Objectives for Today

1. Understand the importance of Revenue Cycle & Reimbursement Collaboration
2. Discuss how the Medicare Cost Report is utilized
3. Comprehend the flow of the Medicare Cost Report
4. Articulate the Key Drivers of Medicare Reimbursement
5. Utilize the Medicare Cost Report to calculate key KPIs & identify Benchmarking trends to improve reimbursement and compliance

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Revenue Cycle

Definition of the Revenue Cycle

- All the administrative and clinical functions, processes and software applications that contribute and manage the registration, charging, billing, payment and collections tasks associated with a patient encounter
- Revenue cycle is the process that begins when a patient comes into the system and includes all those activities that have occurred in order to drive revenue form the patient encounter

Definition of the Revenue Cycle

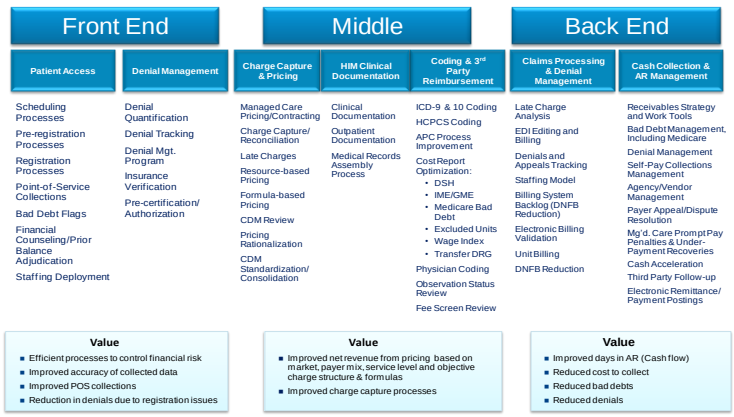
Functions
- Capture (patient days, gross charges, etc.)
- Manage (cost and charge apportionment)
- Collect patient revenue (charity care, Medicare bad debts)

Processes
- Review patient's financial situation (DSH eligibility)
- Issue bills (settlement data reflected in PSR and DSH info)
- Collect payments (settlement data, Medicare bad debts)

Strategies
- Customer receivable valuation (charity care and bad debts)
- Underpayment recovery (outliers, transfer DRGs)
- Third party payer transactions (MSP, DSH)

Complexity of Revenue Cycle

End-to-end revenue cycle focus - Leverage an end-to-end revenue cycle approach, focusing on materially processes, potential system implementation and performance improvement opportunities



Revenue Cycle Process

Assess the organizational structure, process flow, internal controls and potential governance aspects supporting and impacting overall revenue performance; specific components of a the revenue cycle would include the following functional areas:

Patient access: Scheduling, registration, insurance verification, referral management and point-of-service collections

Case management: Medical necessity authorizations, denials management, quantification and tracking

CDM, charge capture and coding: Tools and mechanisms used to capture, document and reconcile patient services and charges for billing purposes; in addition, a high-level technical assessment of the accuracy and completeness of procedural coding and clinical documentation efforts for billing and compliance purposes

Pre-billing and billing functions: Patient statement production and internal/external pre-submission claim review process

Accounts receivable and follow-up functions: Understanding legacy accounts receivable (A/R) implications, as well as monitoring A/R follow-up activities for both third party insurance and self-pay accounts, focusing on effective work flow mechanisms and protocols

Third party denial management: Processes and controls utilized to capture, analyze, appeal and communicate third party claim denials impacting reimbursement and cash flow

Management reporting and communication: Assessment of the availability and utilization of standard and/or customized reports and analyses for the purpose of monitoring and reporting critical performance indicators and related trends; management reporting will also be assessed

Medicare Cost Report Uses

Importance of the Medicare Cost Report

- Report required for all Medicare participating providers-Standardized data gathering tool
- Payment determination for Medicare cost-based entities:
  - Critical Access Hospitals
  - Children's and cancer hospitals
  - Medicaid
  - Blue Cross programs in some states-hospitals are paid estimates from historic data and settlement is based on current actual costs
- Determination monies due to/from the government?
  - Certain services are paid to hospitals using estimates from historical data; the settlement amount is the difference between the historical estimates and the current actual costs or data
  - Certain services are paid prospectively; therefore, no settlement is calculated at the end of the year for these services
  - With most services being paid prospectively, accuracy of the cost report is vital for rate setting and compliance?
- Rate setting
  - MCR data used to develop cost weight MSDRGs, APCs and other prospective methods-services paid prospectively, no settlement at the end of the year
  - MCR data used to determine the labor share of the market basket updates based on wage index CMS and MedPAC uses the MCR to validate adequacy of PPS payments to determine if Medicare is paying proper amounts to providers based on cost report information to compare Medicare costs vs. reimbursement
    - Base Year for future payment regulations
    - Set future rates
    - Detect payments that are not proper
    - Develop\enhance program integrity process
- Compliance
- Benchmarking
- Operational assessments\Education

External (CMS)
- Standardized data gathering tool
- Determination of program liability on annual basis by hospital
- Reconcile interim payments
- Comparison of Medicare cost vs. reimbursement
- Develop future payment amounts and methodology
- Benchmarking across providers
- Investigative tool (establish patterns)

Internal (provider)
- Same as CMS (individual/local/competitive basis)
- Operational assessments and management tool
- Advocacy and education

Importance of the Medicare Cost Report

Cost reports are public information which can be found within the Healthcare Provider Cost Reporting Information System (HCRIS) and Centers for Medicare & Medicaid Services (CMS) websites

Sources/websites:

- https://hcris.hfssoft.com/
- https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports/Cost-Reports-by-Fiscal-Year.html

Medicare Cost Report

Medicare Cost Report Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE 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 OR CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOSPITAL for the cost reporting period … 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 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.

(Signed)

Officer or Administrator of Provider(s)

Cost Report Overview

- WS S – Officer signs certifying cost report is free of material errors
- WS S-2 – Questions drive much of the reimbursement on the cost report
- WS S-3 Pt I – Patient Statistics
  - Count patients in an inpatient bed at midnight
  - Exclude patients in an ancillary area at midnight
  - Exclude L&D patients at midnight unless they have occupied an IP routine bed
  - Medicare days should be filed by discharge date (PS&R)
    - Since Medicare days are based on discharge date, then so should Total, Medicaid, etc.
  - Discharges must be consistent with patient days
- WS S-3 Pt II – Wage Index
  - Measure relative differences between each labor market's average hourly rate and the national average hourly rate
  - Key: Match wage dollars (compensation and benefits) with corresponding hours
  - Salary dollars all flow from WS A (includes reclassifications when properly coded on A-6)
  - All hours and benefit information must be input (including hours related to A-6)
- WS S-10 – Charity Care Reporting

Cost Report Overview

Determine allowable cost
- WS A Series-Determine allowable costs
- WTB

Cost Allocation
- WS B Series
- Statistics
- Step Down Process
  - ✓ Overhead cost centers
  - ✓ Revenue producing & NRCC
  - ✓ Fully allocated costs for apportionment

Cost Apportionment
- WS C & D Series
- Patient revenue, patient days and patient discharges
- Cost to charge ratio
  - ✓ Fully allocated costs for apportionment\total departmental charges=departmental cost to charge ratio
  - ✓ Utilized on D series worksheets to determine program costs

Settlement
- WS E Series
- PS&R, R&U, Medicare Correspondence, lump sums and pass thru payments

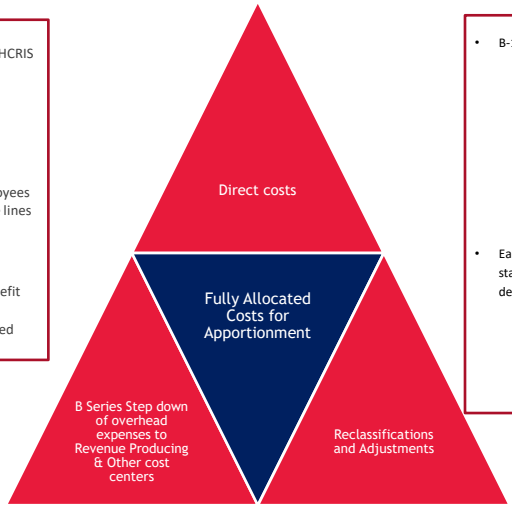
Amount Due to or from provider
- WS S Certification Page
- Summary of E series

Cost Report Process-Allowable Costs & Allocation

WS A – Trial Balance of Expenses
- Grouped expenses (GL mapping to CR lines & HCRIS alignment)
- Reconciled to financial statements
- Do not include bad debt expense

WS A-6 – Reclassification of Expenses
- Reclass expense for proper matching
- Reclass non-reimbursable expenses to NRCC
- Ensure appropriate allocation of shared employees and services between department and service lines

WS A-8 – Adjustment to Expenses
- Offset non-allowable expense
- Develop non-allowable checklist
- State provider tax issues - not allowable if benefit exceeds assessment
- Ensure all non-allowable expenses are identified and eliminated from the cost report



- B-1 Statistics – Allocation of overhead costs
  - Allocation based on recommended basis
    - Can make changes if requested in advance
  - Alternative allocation method – Simplified cost method
    - Requires less maintenance of statistics
    - Once elected, the provider must continue to use this method for no less than three years (unless change of ownership occurs)
    - CMS is evaluating the continuation of this method
- Each department included in an overhead department's statistic should actually provide support services to that department
  - Medical records department may not support all clinics, SNF or other areas since they may have their own medical records department
  - Maintenance may or may not provide services to leased buildings

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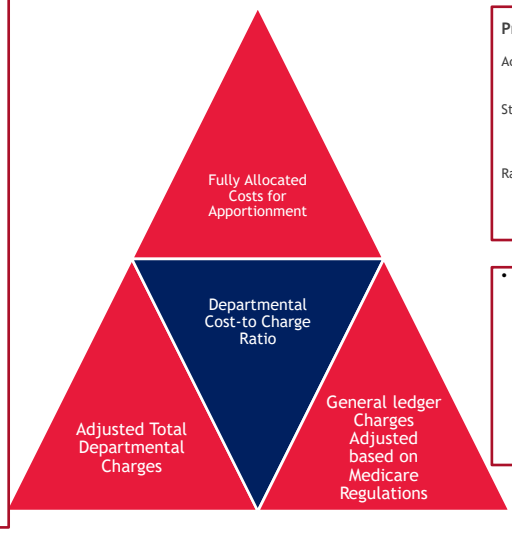
Cost Report Process-Worksheet C-Bridge of the Cost Report

- Fully allocated costs divided by total departmental charges=cost to charge ratio for each ancillary department
- Matching principle-Expenses and charges should be grouped consistently on WS A and WS C. Accurate fully allocated departmental costs for apportionment for payment purposes (CAH) and rate setting (PPS)
  - Match Medicare allowable costs with related cost allocation statistics to accurately determine fully allocated costs for apportionment purposes (WS A and B-1)
  - Match total hospital charges with the costs (WS C)
  - Match program charges with total charges (WS D-3 and D PT V)
- Common revenue adjustments
  - Physician Revenue
  - Self insured charges net of physician revenue removed with physician revenue offset
- Common revenue reclassifications
  - Medical Supplies
  - Implantable
    - ✓ Improve consistency in reporting of these charges between hospitals
    - ✓ Match how hospitals categorize charges on the cost report and how CMS categorizes on MedPar file



Pricing 101

Across the board
- All items priced with the same increase, i.e., 2%

Strategic
- Certain services priced higher if they have a sensitivity, resulting in a higher return, and items without a higher return are priced lower

Rational
- Incorporating cost as the basis for how much your charge per service; this is a defendable pricing

- Rational strategic pricing
  - Taking a rational approach will often result in a negative financial impact, which is why many organizations focus on strategic pricing. **Rational strategic pricing** leverages both of them together**;** we model contracts to develop sensitivity for each service. The analytics are then used to drive how to price items and getting all charges, over the course of multiple years, to a rational mark up to cost

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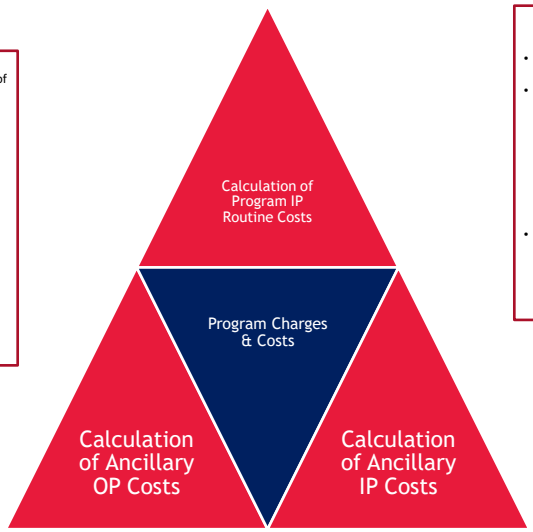
Cost Report Process-Worksheet D Series-Apportionment

- Medicare uses the cost report to determine its share of each department's cost based on Medicare utilization
- Utilization is measured by
  - Nursing units – days
    - Routine
    - ICU
    - Psych
    - Rehab
    - SNF
  - Ancillary departments – charges (important that there is a consistent charge structure)



- WS D Part V – Calculation of Medicare O/P Costs
- WS D-1 – Calculation of Medicare I/P Costs
  - Routine costs
  - Calculation of non-distinct part observation costs
  - Comparison to TEFRA limits
- WS D-3 – Calculation of Medicare I/P Ancillary Costs
  - Separate worksheets for I/P, psych, rehab, etc.

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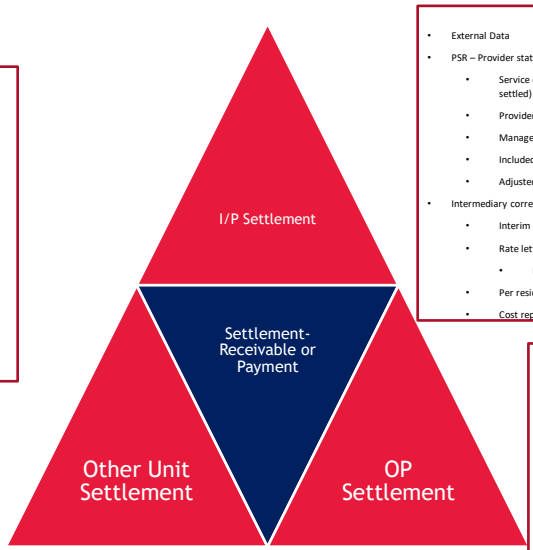
Cost Report Process-Worksheet E Series-Settlement

- Internal data
  - Census data (patient days and discharges)
    - Total facility
    - Financial class
  - Revenue and usage reports
    - Departmental charge distribution
    - Procedure
    - UB04 revenue codes (matching)



- External Data
- PSR – Provider statistical and reimbursement report (how often obtained)
  - Service dates (splits) vs. run dates (update when cost reports are amended or settled)
  - Provider components
  - Managed care reports
  - Included and excluded reports
  - Adjusted for RAC activity
- Intermediary correspondence (where are these maintained)
  - Interim payments (bad debts; GME; organ acquisition)
  - Rate letters
    - DRG base rates
  - Per resident amount updates
  - Cost report due dates and acceptance

- E-1 Interim Payments
- Match payments with data – PS&R vs. internal data
- Include net reimbursement amount related to MCO activity
- Include full period of biweekly-level payments – checks vs. accrual
- Match lump sum adjustments to cost report period – receipt date vs. applicable period
- Separate schedule for each provider component

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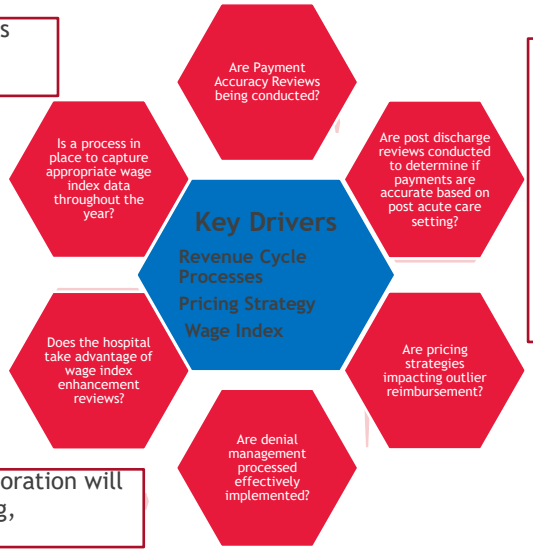
Key Drivers of Reimbursement

Key Drivers of Reimbursement-Settlement

Revenue cycle collaboration is key to a successful reimbursement.



Key Considerations

- Is pricing strategy impacting outlier reimbursement?
  a. Across the board
  b. Strategic
  c. Rational
  d. Rational Strategic
- Has the hospital assessed the current revenue cycle processes compared to best practices in the revenue cycle?
- How is denial management conducted at the hospital
- Is there a wage index improvement initiative undertaken by the hospital

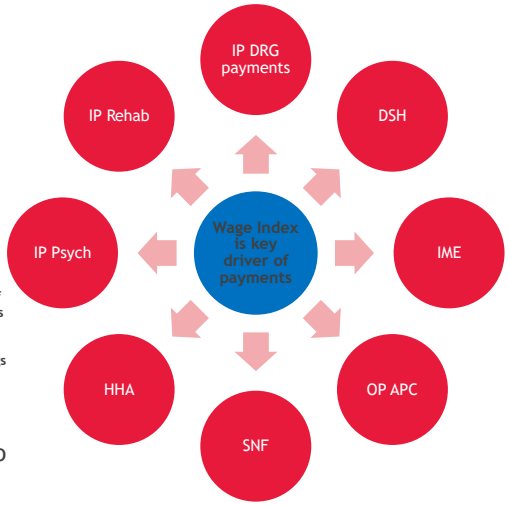
RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Wage Index

Measures relative differences between each labor market's average hourly rate and the national average hourly rate

- **Key Considerations**
- **Is wage index accurately completed at the time of the Medicare cost report submission?**
- **Do all stakeholders (Finance, Reimbursement, Payroll, HR, AP) collaborate in the process?**
- **Are detailed reviews completed for the key drivers to ensure all relevant data is included and the correct codes and amounts are excluded?**
- **Is the PUF reviewed for discrepancies after filing of the Medicare cost report and after relevant reviews by the MAC completed?**
- **Does the CBSA conduct wage index market meetings for discussion of audit adjustments, identified discrepancies in reported data and best practices?**

Data is accumulated at the hospital level, aggregated into CBSA groupings and indexed against nationwide data set



Every Hospital's WI matters in overall CBSA's AWI:

- Hospitals in CBSA need to collaborate
- CMS computes the AHW for each hospital, CBSA and the nation
- Adjusted salaries and hours for all hospitals in a CBSA in each state are added together to compute an AHW for the CBSA
- CBSA is then compared to the National AHW

Key Drivers of Reimbursement-DSH Payments

Revenue cycle collaboration is key to successful reimbursement.

Key Considerations

- Are payment accuracy reviews conducted?
- Are post discharge location verification reviews conducted (Transfer DRG)
- Are Medicare rates Updated?
- Are denial management processes in place and followed?
- How are Medicaid days identified, verified and all eligible days reported?
- Is SSI percentages reviewed and verified against internal SSI data?

RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Drivers of Reimbursement-UCC Payments

Revenue cycle collaboration is key to successful reimbursement.

RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Considerations

- Have charity care, financial assistance and bad debt policies been updated to meet uncompensated care regulations?
- Are transaction codes properly identified and utilized for correct identification of all charity care and bad debts?
- Is the detailed listing of charity care and bad debts properly developed and submitted with the Medicare cost report?
- Have charity care and bad debts been reconciled to the audited financial statements?
- Is the revenue and usage report reviewed and scrubbed to eliminate all professional charges from charity care?

Key Drivers of Reimbursement-340B

Revenue cycle collaboration is key to a successful reimbursement.

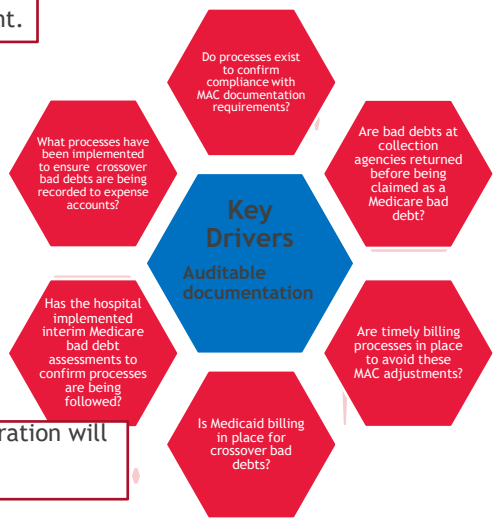
RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Considerations

- How are Medicaid days identified, verified and all eligible days reported?
- Is SSI percentages reviewed and verified against internal SSI data?
- Are risk assessments conducted to ensure compliance with regulations
- Do all stakeholders participate in staff training
- How are new regulations monitored and impact to the organization developed?
- Is the patient utilizing the 340Bdrugs identified appropriately

Key Drivers of Reimbursement-Medicare Bad Debts

Revenue cycle collaboration is key to successful reimbursement.



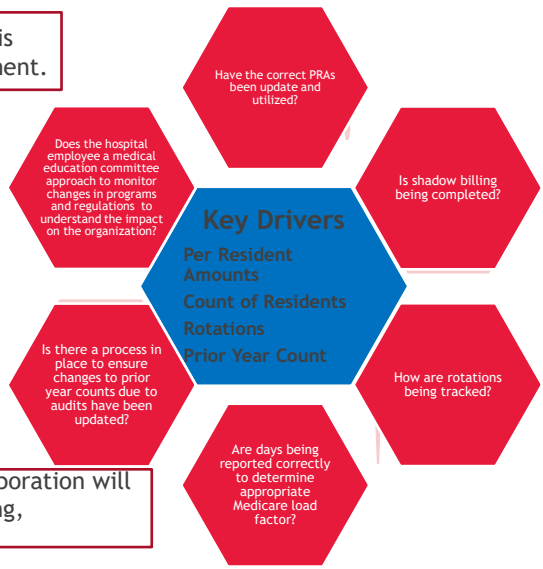
RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Considerations

- How does the hospital confirm compliance with MAC documentation requirements?
- Are Medicare bad debt policies up to date and followed?
- How are bad debts at collection agencies handled before claiming as a Medicare bad debt?
- Does the hospital bill patient portion in a timely fashion?
- Has there been significant audit adjustments to claimed Medicare bad debts?
- Doe the hospital bill Medicaid for the patient deductible portion of crossover bad debts?
- Are Medicare bad debts recorded to bade debt expense?
- Has the hospital implemented interim bad debt audits to confirm processes are being followed?

Key Reimbursement Drivers-DME

Revenue cycle collaboration is key to successful reimbursement.



RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Considerations

- How are rotations tracked?
- Have all the correct update factors been applied?
- Does the hospital perform shadow billing for Medicare Managed Care (MCO)?
- Are prior year FTEs been updated based on Medicare audits?

Key Drivers of Reimbursement-IME

Revenue cycle collaboration is key to successful reimbursement.

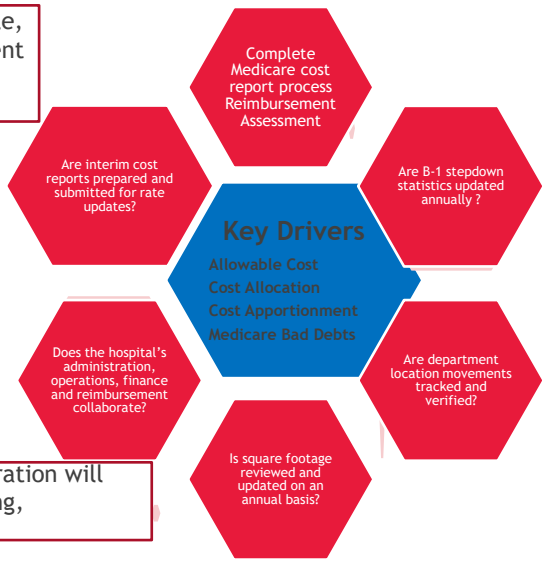
Key Considerations

- How are rotations tracked?
- Is there a bed management inventory committee and report tracking bed closures and unit openings?
- Does the hospital perform shadow billing for Medicare Managed Care (MCO)?
- Are prior year FTEs been updated based on Medicare audits?

RC and Reimbursement collaboration will enhance accuracy of reporting, compliance and payments.

Key Drivers of Reimbursement-Critical Access Hospital (CAH)

Administration, Revenue cycle, Operations and Reimbursement collaboration is key to successful reimbursement.



Key Considerations

- Has the hospital conducted a Medicare reimbursement assessment?
- Does the hospital update B-1 statistics on an annual basis?
- Are department locations movements tracked and square footage statistics updated?
- Does the hospital prepare interim Medicare cost reports to update payments rates at least twice per year?

Hospital department collaboration will enhance accuracy of reporting, compliance and payments.

KPIs & Benchmarking

Medicare KPI's and Dashboards

- Using key performance indicators (KPI) is considered a best practice to inform the Hospital Administration, Finance and Audit Committee about what is happening in the healthcare industry and how the Organization compares to their peers in the industry.

- Financial KPI Report
  - Payer Mix-Determine how much revenue from Government payers compared to private and self pay
  - Average Length of Stay-Average number of days a patient stays in the hospital offers insights into efficiency of care
  - AR Days-Gross-Average number of days for an organization to collect (40-45 days)
  - AR Days-Net-Average number of days to collect after D&C (40-45days)
  - Bad Debt Write Off Percentage-Percentage of patient revenue expected to be paid written off (<3%)
  - Charity Care Write Off Percentage-% of patient revenue not expected to be paid written off (<3)
- Medicare Bad Debt Report
  - Medicare Bad Debt Compared to Coinsurance and Deductible
  - Percentage of Medicare bad Debt to Coinsurance and Deductible
  - Five-year trend of Medicare Bad Debt
- Cost Analysis Report
  - Comparison of Cost and Reimbursement
  - Comparison of Days and Discharges
- Uncompensated Care Report
  - Trend of Uncompensated Care-Charity Care & Bad debt
  - Trend of Uncompensated Care percent of Gross Patient Revenue
- Margin Report
  - Margin/Deficit for Medicare
  - Cost and Reimbursement Analysis
  - Medicare Cost Report Settlement Analysis

AR Days-Gross

AR Days (Gross)

- Average number of days it takes an organization to collect payment
- **KPI**:
  - Accounts receivable (A/R) days (Gross): **40-45 days**
    - Per industry best practices, A/R days should be between 40-45 days; however, the target range for gross A/R days may differ between organizations. Depending upon various organizational factors (i.e., high service pricing, contracted rates, write-offs), gross A/R days greater than 40-45 days may not necessarily indicate that the organization is performing poorly. Similarly, gross A/R days less than 40-45 days may not necessarily indicate that the organization is performing optimally.
- **Potential opportunity**:
  - If A/R is > 55-60 days, there may be an opportunity to enhance the efficiency of the organization's revenue cycle since it is not collecting receivables in a timely or effective manner
    - A potential issue may exist regarding the organization's billing department, collection efforts, rejected claim rate, etc.
- **Calculation:**

Net days in accounts receivable equation:

$$\frac{\text{Accounts receivable}}{\text{(Gross patient revenue/365)}}$$

Net days in accounts receivable equation within cost report:

$$\frac{\text{WS G, Line 4, Col 1}}{\text{(WS C, Part I, Line 202, Col 8/365)}}$$

AR Days-Net

AR Days (Net)

- Average number of days, after deducting contractual and uncollectible allowances, it takes an organization to collect payment dues
- **KPI**:
  - Accounts receivable (A/R) days (Net): 40-45 days
    - Compared to gross A/R days, net A/R days excludes contractual and uncollectible allowances and is a more accurate reflection of an organization's true performance.
- **Potential opportunity**:
  - If A/R is > 45 days, there may be an opportunity to enhance the efficiency of the organization's revenue cycle since it is not collecting receivables in a timely or effective manner
    - A potential issue may exist regarding the organization's billing department, collection efforts, rejected claim rate, etc.
- **Calculation:**

Net days in accounts receivable equation:

$$\frac{\text{(Accounts receivable – Uncollectible allowances)}}{\text{(Net patient revenue/365)}}$$

Net days in accounts receivable equation within cost report:

$$\frac{\text{(WS G, Line 4, Col 1 – WS G, Line 6, Col 1)}}{\text{(WS G–3, Line 3, Col 1/365)}}$$

Write-Off Percentage-(Gross)

Bad Debt Write-Off Percentage (Gross)

- Percentage of gross patient revenue that is written-off for outstanding services in which organizations anticipated but did not receive payments from patients and/or payers (i.e., private and government)

- **KPI:**
  - Bad debt write-offs as a percent of gross patient revenue: < 3%

Potential opportunity:

- If the bad debt write-off percentage is > 3%, an issue may exist in collecting payments
  - There may be an opportunity to increase collection efforts within pre-service, point-of-service or post-service (i.e., customer service) areas

- **Calculation:**

Bad debt % of gross revenue equation:

$$\frac{\text{Bad debt write-off}}{\text{Gross patient service revenue}} * 100$$

Bad debt % of gross revenue equation within cost report:

$$\frac{\text{WS S-10 Line 26}}{\text{WS C, Part I, Line 202,Col 8}} * 100$$

Charity Care Write-Off Percentage (Gross)

- Percentage of gross revenue that is written off for outstanding service payments in which organizations did not anticipate payments due the patient's inability to pay

- **KPI:**
  - Charity care write-offs as a percent of gross patient revenue: < 3%
    - Charity target is subject to change based on an organization's specific community needs and its financial assistance policy

- **Potential opportunity:**
  - Charity care write-off percentage of > 3% may indicate:
    - An opportunity for financial counseling to increase conversion rates
    - An opportunity to modify the organization's existing charity care policy as designated by industry best practices and community needs

- **Calculation**

Charity care write-offs as a percent of gross patient revenue equation:

$$\frac{\text{Charity care write-off}}{\text{Gross patient service revenue}} * 100$$

Charity care write-offs as a percent of gross patient revenue equation within cost report:

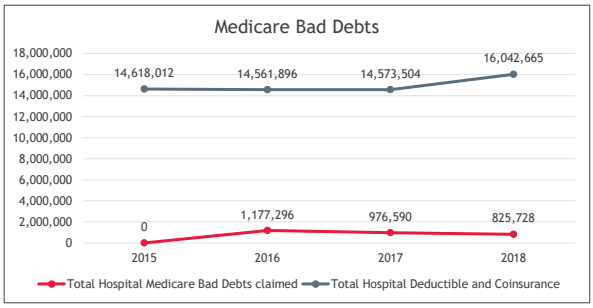
$$\frac{\text{WS S-10, Line 20, Col 3}}{\text{WS C, Part I, Line 202, Col 8}} * 100$$

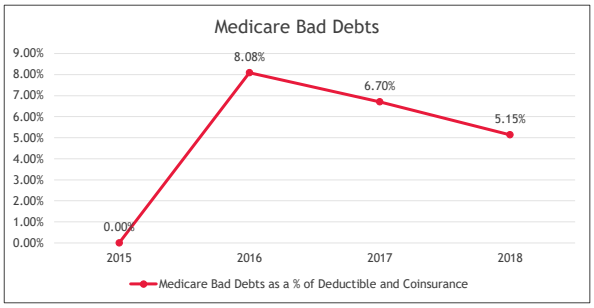
Key Performance Indicators (KPI's)

	Hospital System I			*Hospital System II*		*Hospital System III*	*Hospital System IV*		*Hospital System V*		
	A	B	C	D	E	F	G	H	I	J	K
Medicare Payor Mix											
Days	12,865	30,534	3,148	7,154	4,361	7,594	19,515	5,336	4,369	7,036	15,382
% of Total Days	25%	29%	29%	24%	32%	32%	26%	25%	33%	26%	34%
Medicaid Payor Mix											
Days	6,253	13,524	550	2,596	574	919	2,908	490	2,601	3,929	11,903
% of Total Days	12%	13%	5%	9%	4%	4%	4%	2%	20%	15%	26%
Private/Self Pay/Other Payor Mix											
Days	31,993	62,476	6,979	19,710	8,752	15,192	52,739	15,728	6,315	16,131	17,643
% of Total Days	63%	59%	65%	67%	30%	64%	70%	73%	48%	60%	39%
Average Length of Stay											
Medicare	5.32	5.48	4.72	4.57	4.40	5.86	4.76	4.19	6.00	4.31	4.34
Medicaid	3.89	2.06	4.33	8.95	7.65	0.61	2.17	1.47	6.18	2.49	3.17
Private/Self Pay/Other	5.39	8.01	3.25	3.78	3.81	7.47	5.59	4.73	7.15	5.13	4.92
Accounts Receivable	$25,406,149	$50,863,804	$37,133,196	$78,151,445	$19,681,292	$21,304,470	$71,347,328	$16,451,699	$10,362,274	$23,746,161	$33,649,240
Gross Patient Revenue	$618,824,997	$1,255,799,660	$367,655,365	$601,231,321	$531,651,786	$507,841,191	$3,772,146,323	$942,176,977	$229,400,295	$629,767,080	$964,331,310
A/R Days (Gross)	14.99	14.78	36.87	47.44	13.51	15.31	6.90	6.37	16.49	13.76	12.74
Uncollectable allowances	$0	$0	$25,088,720	$51,958,169	$0	$0	$0	$0	$0	$0	$0
Net patient Revenue	$174,715,567	$289,973,898	$64,278,715	$183,600,494	$146,014,089	$86,652,403	$545,038,538	$144,397,581	$70,006,629	$181,559,768	$246,151,470
A/R Days (Net)	53.08	64.02	68.39	52.07	49.20	89.74	47.78	41.59	54.03	47.74	49.90
Bad Debt Write-Off	$8,892,446	$16,040,352	$3,565,504	$7,606,835	$7,122,419	$5,906,725	$17,011,276	$6,142,620	$5,476,643	$13,054,132	$12,477,115
Bad Debt Write-Off Percentage (Gross)	1.4%	1.3%	1.0%	1.3%	1.3%	1.2%	0.5%	0.7%	2.4%	2.1%	1.3%
Charity Care Write-Off	$3,778,097	$14,835,163	$1,052,567	$689,821	$2,180,251	$26,307,073	$29,449,234	$8,184,323	$861,934	$1,167,817	$6,846,263
Charity Care Write-Off Percentage (Gross)	0.61%	1.18%	0.29%	0.11%	0.41%	5.18%	0.78%	0.87%	0.38%	0.19%	0.71%

NOTES
yellow = further analysis needed
green = within industry best practice
red = potential opportunity to enhance efficiency

Medicare Bad Debt Trend Analysis





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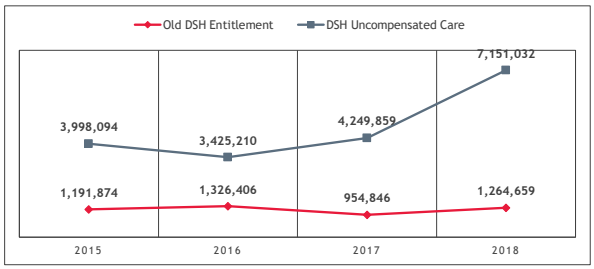
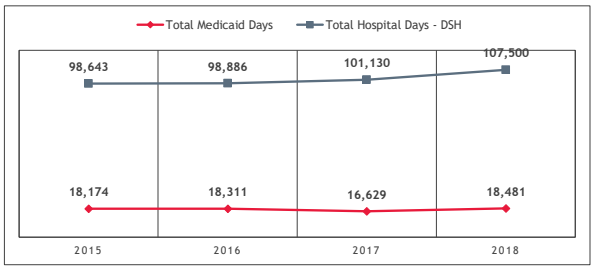
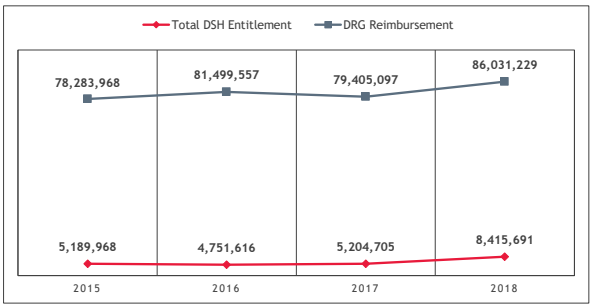
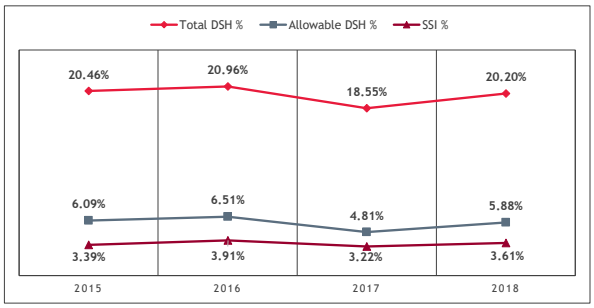
DSH Trends









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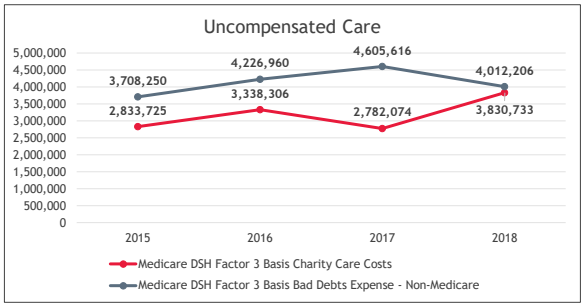
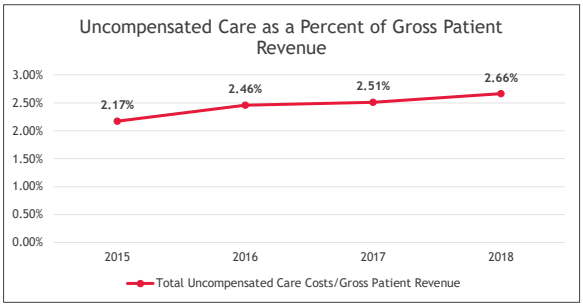
Uncompensated Care Trend Analysis





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