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"Show You the Money" – Finding Your Own Rural Hospital Strategic Financial and Reimbursement Improvements

2026 MN Rural Health Forum

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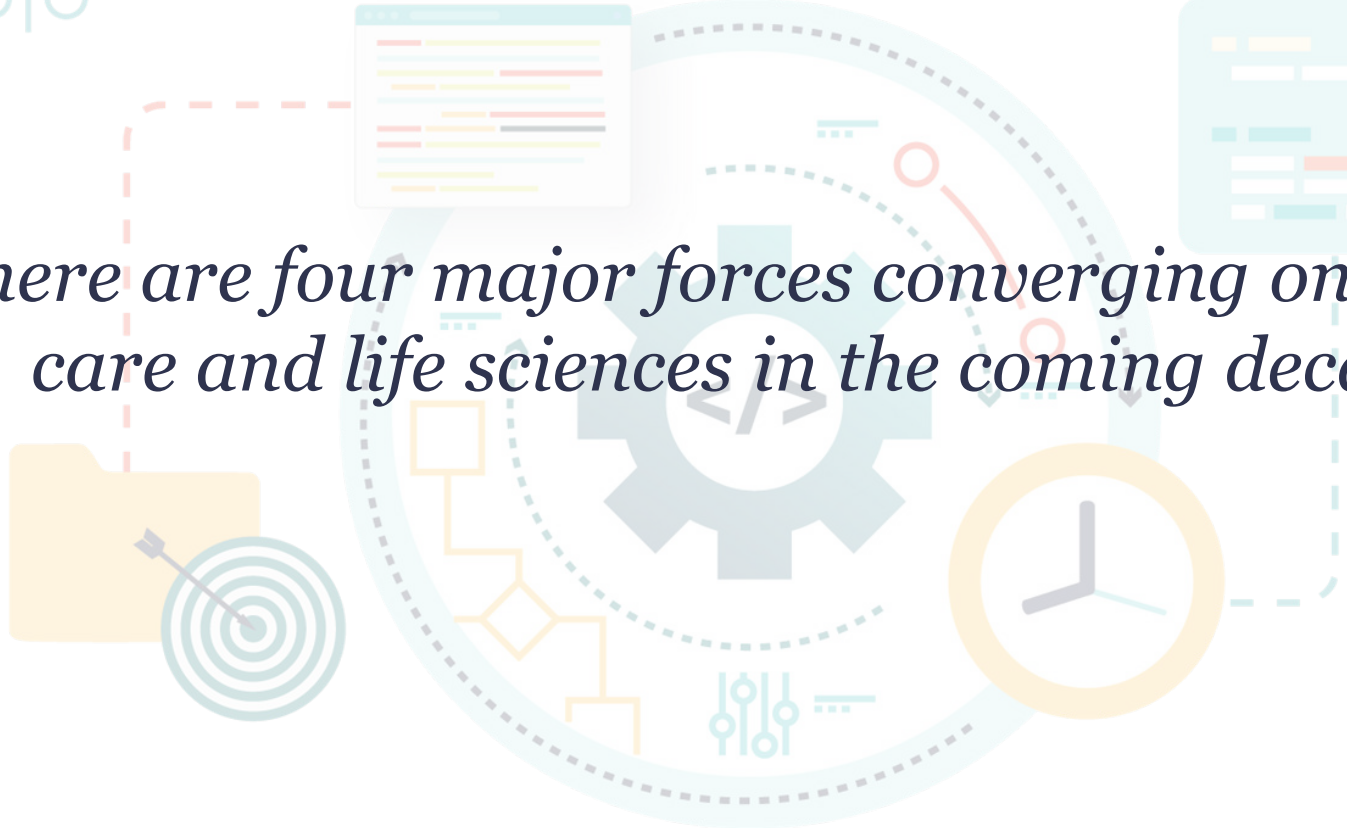
Learning Objectives

- Gain insights from real-world scenarios and case studies highlighting successful strategies and common pitfalls
- Be able to take thoughts and ideas back to your facility to identify areas where finances can be optimized
- Demonstrate tools used to monitor and understand departmental and payer profitability
- Have an enhanced understanding on how to position your facility to assure you are optimizing revenues and expenses for all services that you are providing.
- Provide some reimbursement examples on ways to enhance your current performance

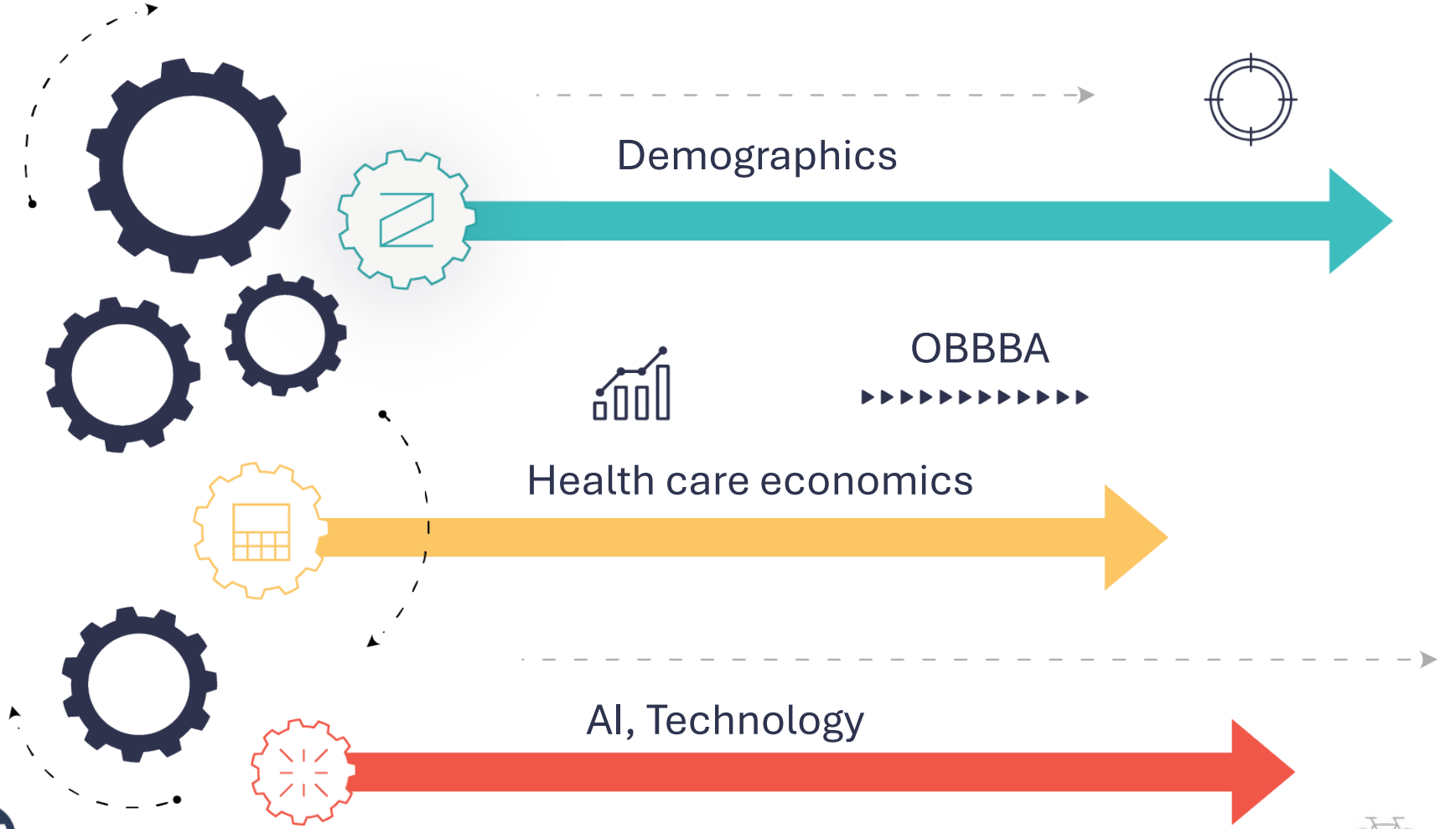
Agenda

- Where is healthcare heading and what can we do about it?
- Financial and Profitability Modeling
- Reimbursement Optimization Ideas – Opportunities and Risks

Navigating the future



There are four major forces converging on health care and life sciences in the coming decade.



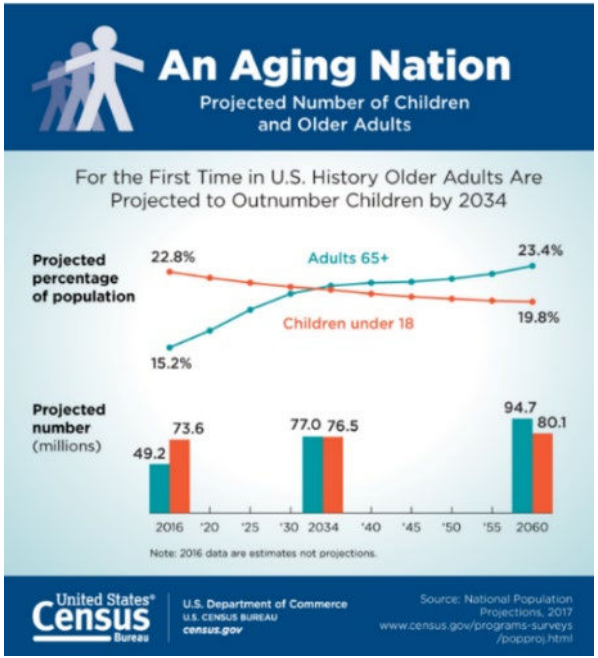
Where you sit in the health care and life sciences ecosystem matters for what these forces mean for you and your business.

Demographics

Generational Cohorts

Generation	Birth Years	U.S. Population (Approx.)	Workforce
Silent Generation	1928–1945	19.0 million	Out of workforce
Baby Boomers	1946–1964	71+ million	Retired or retiring
Generation X	1965–1980	61 million	Later career, leadership years
Millennials (Gen Y)	1981–1996	74 million	Early-mid career
Generation Z	1997–2012	69 million	Early career or moving into workforce in coming years
Generation Alpha	2013–2024	51.5 million	Not in workforce yet
Generation Beta	2025–2039	Not yet measurable	Not in workforce

Demographics



An Aging Nation: Projected Number of Children and Older Adults

- An aging population
- Lower birth rates
- Longer life expectancy
- More chronic conditions

- Increasing need for care, services, housing
  - Senior housing
  - Aging in place
  - Holistic environments
- Increasing role for integrated care, care management
  - Prevention
  - Wellness
  - Breaking down silos
  - Alternative sites of service
- Increasing pressures on workforce supply
  - New pipelines
  - Top of scope
  - Employee needs, satisfaction
  - Upskilling

Health Care Economics

Demographics Impact Health Care Economics

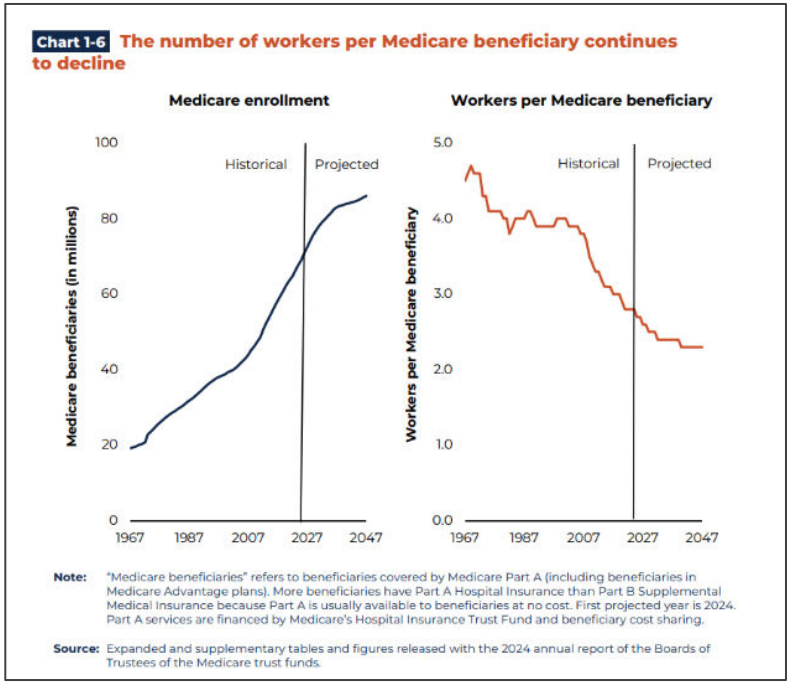
- Timing of generations, retirement waves
- Smaller working age-to-retirement ratios
- Longer life expectancy
- More chronic conditions
- Higher health care costs

For Context: Medicare

78 million people eligible for Medicare *by 2030*

Workers paying into Medicare have declined

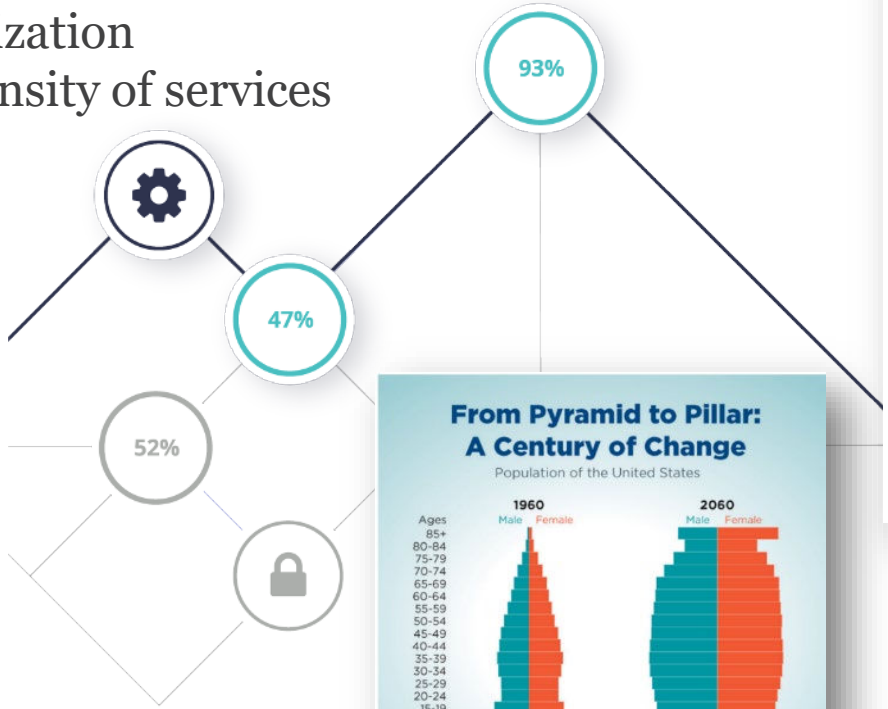
Part A Trust Fund Insolvency *by 2033*

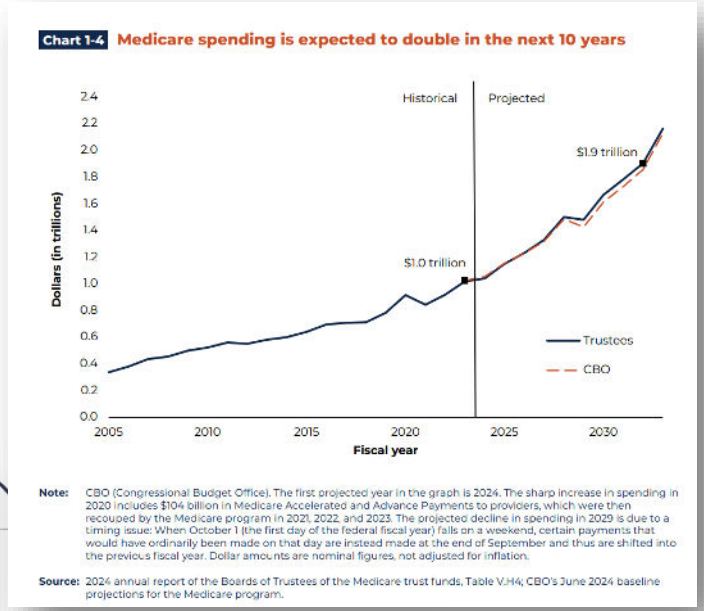


March 2025 Report to the Congress: Medicare Payment Policy – MedPAC

Medicare growth drivers

1. Number of beneficiaries
2. Utilization
3. Intensity of services





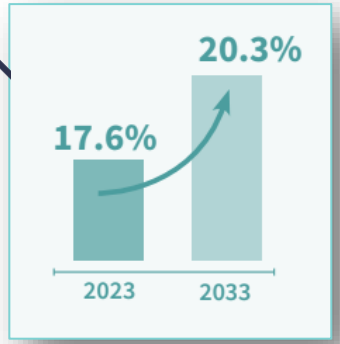
July2025_MedPAC_DataBook_Sec1_SEC.pdf

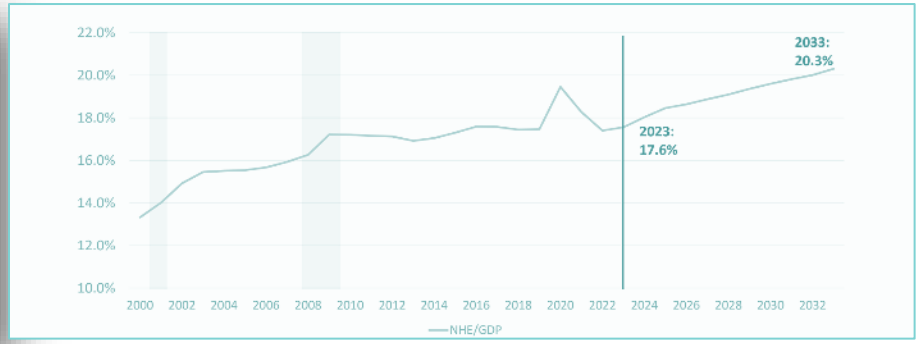
https://www.census.gov/library/visualizations/2018/comm/century-of-change.html

National Healthcare Expenditures to GDP

In next decade…

- NHE projected to grow annually at 5.8%
- GDP growth projected at 4.3%
- Health spending of GDP to go from to 20.3% by 2033



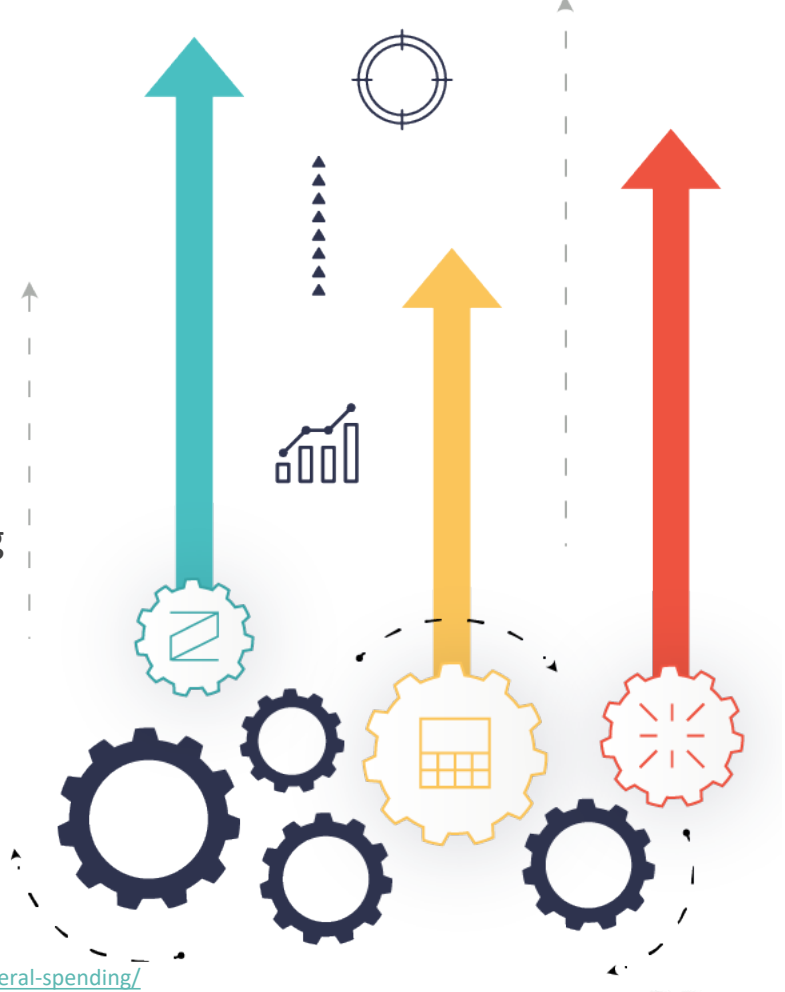


National Health Expenditure Projections 2024–33

https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

The Coming Decade

- NHE up across all payers; Government will finance 50% of health care spend by 2033
- Macroeconomic trends, including tariff policies and geopolitical conditions, impact the cost of goods, supplies, building facilities etc
- In 2025, federal government spent $355 billion to maintain the debt—that's 19% of federal spending
- Total government debt = $38 trillion
- Within two decades, federal spending on four items—Medicare, Medicaid, Social Security and federal debt payments—will exceed all federal revenues coming in.



https://www.cbo.gov/publication/61270
National Health Expenditure Projections 2024–33
https://fiscaldata.treasury.gov/americas-finance-guide/federal-spending/
Understanding the National Debt | U.S. Treasury Fiscal Data
https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/

Future

Increasing role of value, outcomes-based models, services, approaches

Strategic mergers and acquisitions throughout ecosystem

Significant changes in sites of services settings

Rapid technology and AI enablement uptake

More unique partnerships to maintain viability, compete or grow

OBBBA

Major Impact Areas

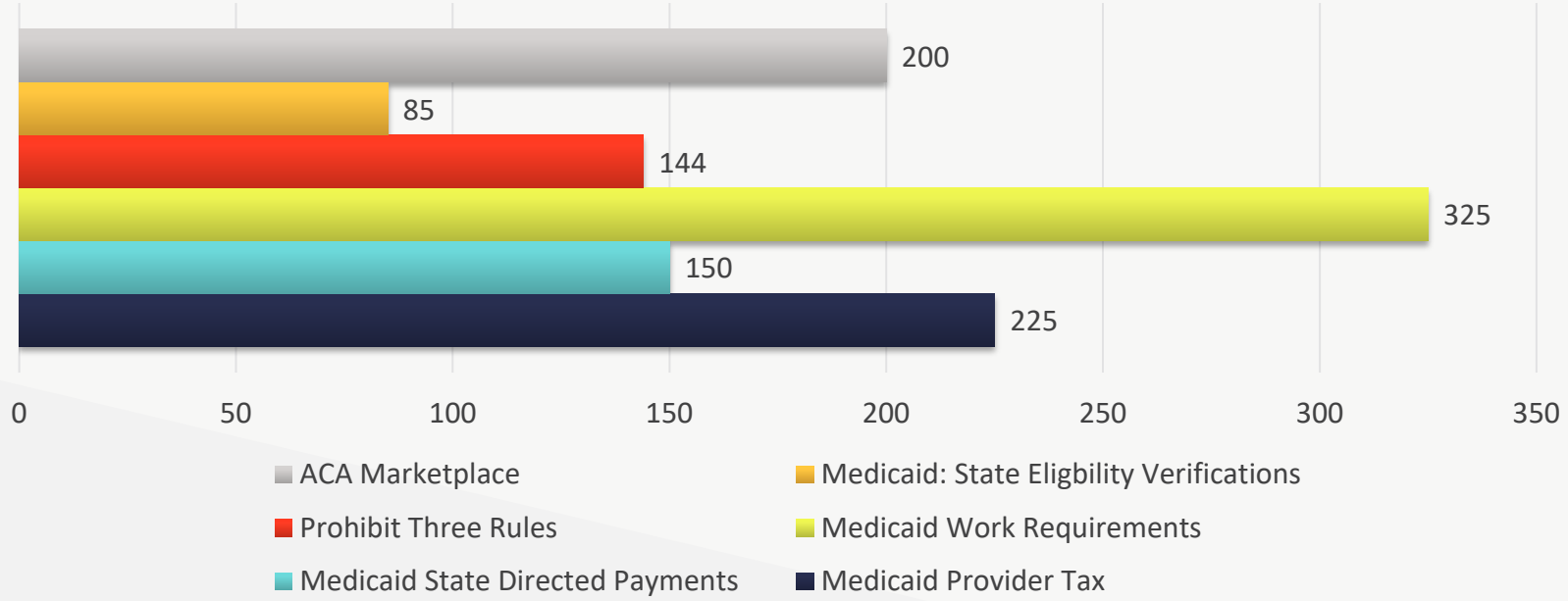
Medicaid Coverage and Financing Policies

$50 Billion in Rural Health Funds

Tax, Credit Policies

Quick Estimate: Major OBBBA Cuts

(in Billions)



Estimated Budgetary Effects of Public Law 119-21, to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Relative to CBO's January 2025 Baseline | Congressional Budget Office

Provider Taxes + SDP + ACA Expansion

	ACA Expansion	ACA Non-Expansion
State	All others	AL, FL, GA, KS, MS, SC, TN, TX, WI, WY
OBBBA Provider Tax Policy Impact	• No new provider taxes • Beginning phase down FFY 2028 as follows: • Nursing home, ICF/ID exempted	• No New Taxes • Existing Taxes Frozen
OBBBA State Directed Payment Policy Impact	• Phases down to 100% Medicare • Begins CY 2028 • 10% reduction per year	• Phase down to 110% Medicare • Begins CY 2028 • 10% reduction per year

Year	Percentage
2028	5.50%
2029	5.00%
2030	4.50%
2031	4.00%
2032	3.50%

2026-2030: Rural Health Transformation Fund

$50 billion Total

$10 billion per year

50% of funds go to states equally

50% determined by HHS (ex: based on specific rural metrics and state application scoring)

Application

States submit 1 application for all five years

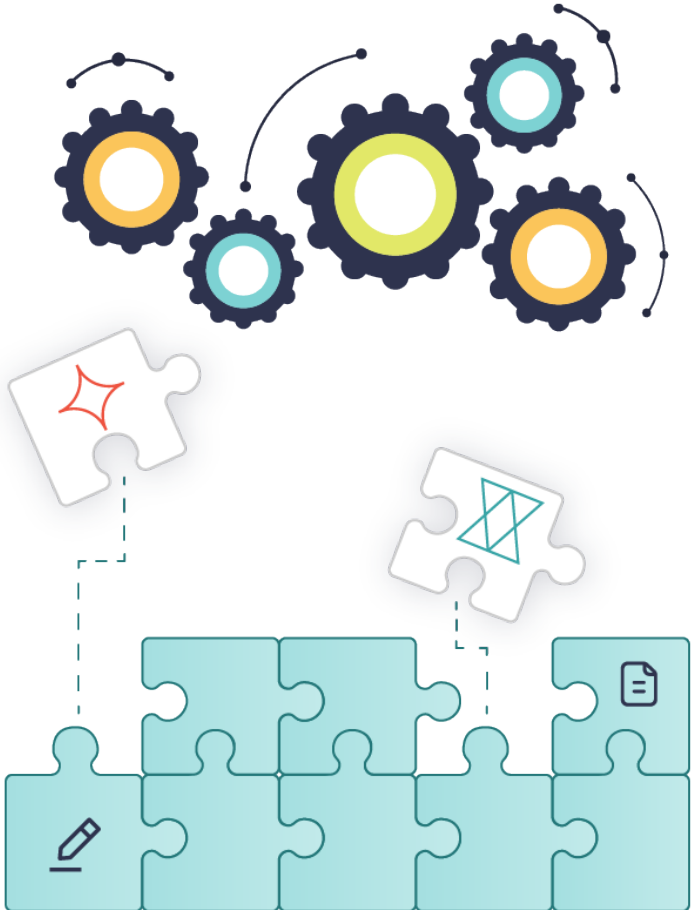
HHS approved applications Dec. 29, 2025

Staes will determine downstream distribution of funds

Each state's use of funds will differ

Rural Health Transformation (RHT) Program | CMS

H.R.1 - 119th Congress (2025-2026)| Congress.gov | Library of Congress



Cross-Cutting RHTF Themes

Technology. Addressing cybersecurity, remote care, telehealth, EHRs, interoperability

Workforce development. Recruiting and retaining workforce, expanded pipelines, rural residencies and rotations, emergency services

Chronic disease management, prevention. Promoting disease management, wellness

Maternal health care. Improving maternal and perinatal care, remote fetal monitoring, digital obstetrics, regionalized work

Sustainable, innovative care models. Creating hub-and-spoke models, shared-service networks, value-based payment reforms

Artificial Intelligence

AI will transform health care and life sciences

AI: The Coming Decade...

Low Hanging Fruit (now)	*Groundbreaking (coming)*
Administrative efficiency (ex: revenue cycle, workflows, patient experience)	Drug discoveries (ex: foundation models, digital twin)
Clinical documentation (ex: AI scribe, coding)	Clinical care (ex: AI diagnostics, AI driven care plans)
Connecting siloed data (ex: surfacing insights)	Robotics (surgeries)
Digital tools, apps (ex: wellness, prevention)	Personalized medicine (“bespoke”)
Predictive analytics (ex: scheduling, staffing, ACOs, population health, decompensation)	Brain-computer interfaces

Robust Governance, Cybersecurity

Where to start?

- What is our current state? Where do want/need to be (future state)?
- How will shifting demographics (aging populations, diverse communities) change demand for our services, products, or workforce over the next decade?
- Are we prepared for the surge in chronic disease and long-term care needs associated with an aging population? How are we redesigning care models to meet them?
- What levers do we have to meaningfully reduce total cost of care while improving outcomes? Where are we currently creating unnecessary cost or friction?
- How will changes in Medicaid enrollment, OBBBA policy updates and state changes impact our revenue, patient mix, or operational risk?
- Are we proactively modeling multiple federal and state Medicaid/OBBBA policy scenarios to understand financial exposure?

Where to start?

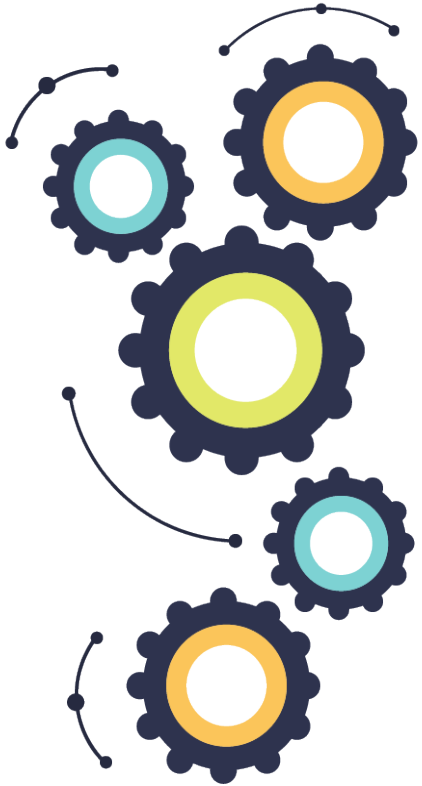
- Where can AI and emerging technologies drive the most value today—administrative burden reduction, clinical decision support, R&D acceleration, supply chain optimization, or patient experience? In the future?
- Do we have a trustworthy and compliant data foundation that allows us to responsibly use AI without creating risk, bias, or inefficiency?
- Are we developing the workforce skills necessary for an AI-augmented healthcare environment—both to adopt technology and to manage the change?
- How are we creating simpler, more human patient and member experiences?
- Are we investing in capabilities that will still be relevant 5–10 years from now, or are we locked into legacy models that can't adapt to these forces (demographic, costs, policy, AI/technological)?

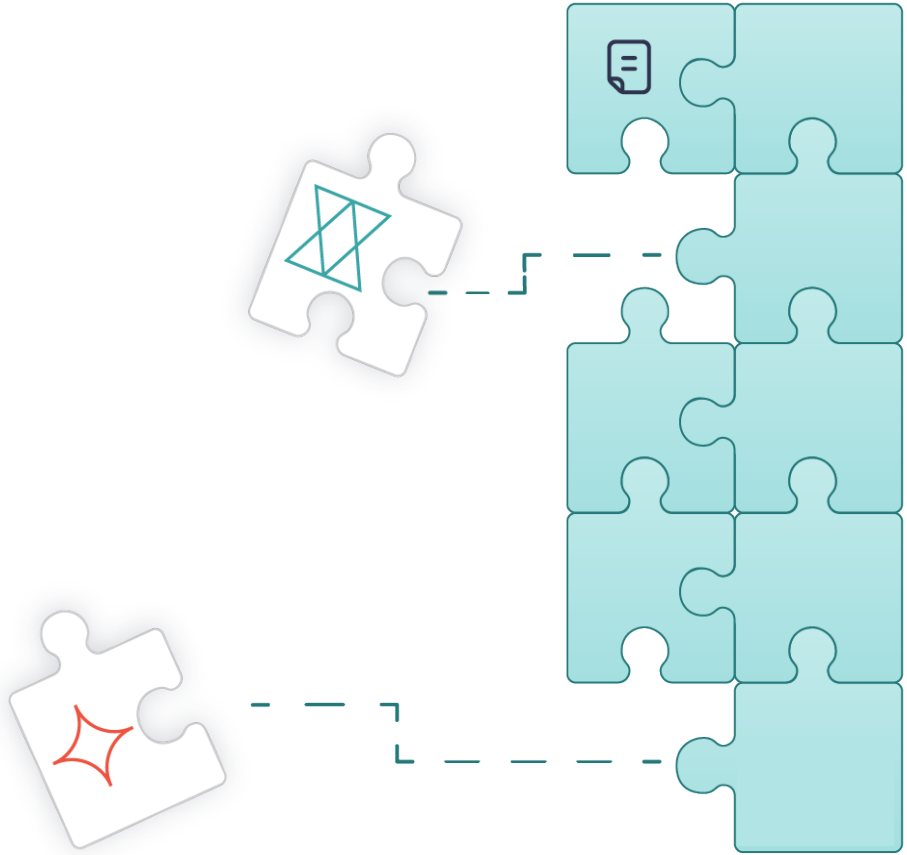
Frameworks, Tools, Models to Assist?

- PEST(LE)
- SWOT
- Porters Five Forces
- Survey tools, analysis
- Market analysis
- Financial modeling
- Scenario planning
- Feasibility study
- Risk assessments
- Workforce planning
- Succession planning
- AI (predictive analytics, forecasting)
- Many more

Financial Modeling

Info & Insights + Strategic Decisions = Clearer Future





Sample Case Study

Small, rural hospital knows they need to stabilize and grow due to demographics, OBBBA policies and health care costs pressures.

Rural Critical Access Hospital: Current State

- An aging demographic
- A poorer demographic
- 70% Medicare, Medicaid payer mix
- Lack of primary, specialty care
- Underutilized post-acute opportunities
- Inefficient revenue cycle, workflows

$16.5M Operating Revenues

Performance Indicators

- -$3.5M Operating Margin
- -$300M Total Margin

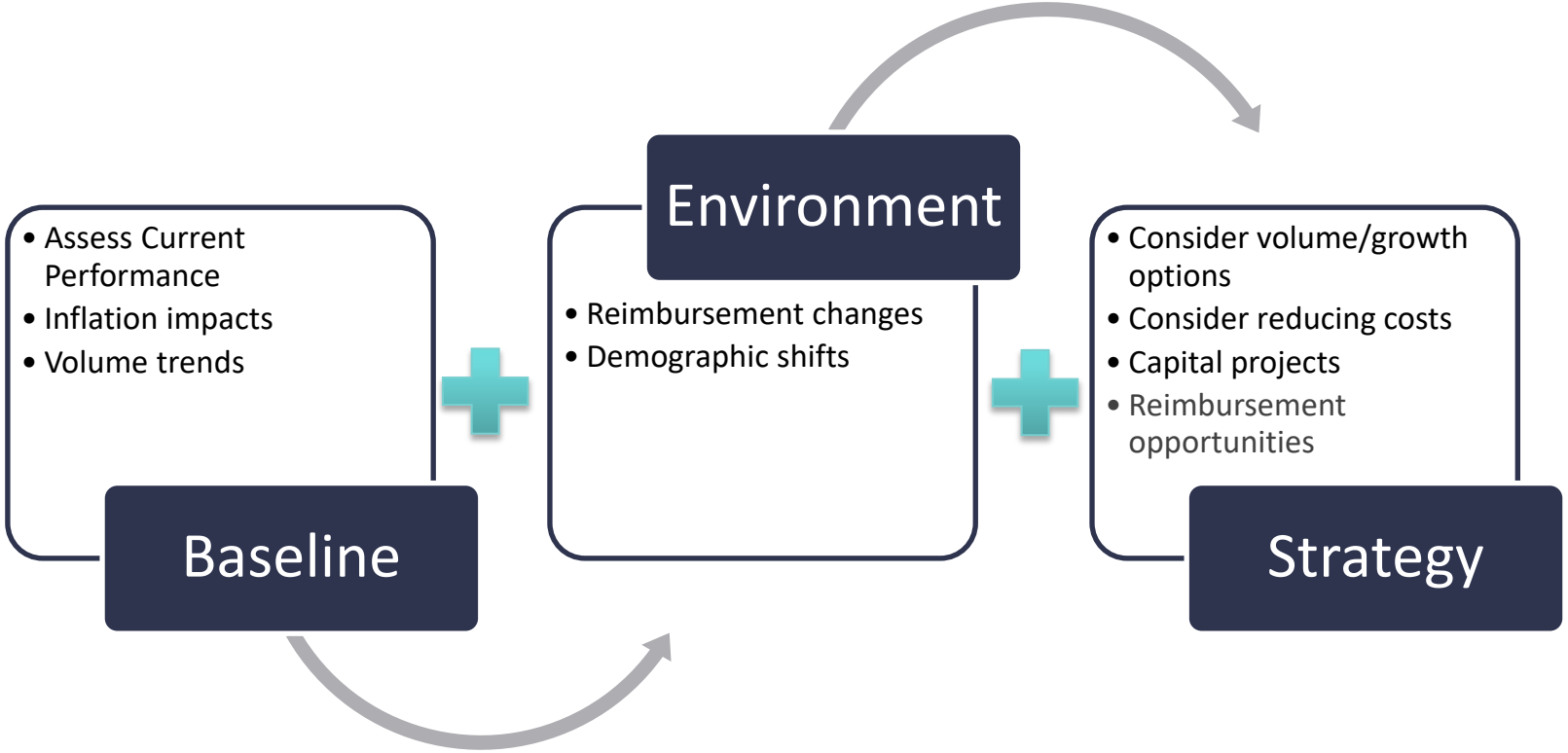
Liquidity and Reserves

- $1M Cash & Reserves
- 20 Days Cash on Hand

Debt and Capital Structure

- No Long-Term Debt

Basics of the Process



Strategic Financial Modeling

Interactive

Allows “If, if, if…” Scenarios

Impactful Real Time Analysis

Ease of Use

Can be Modified

User Friendly

High Level

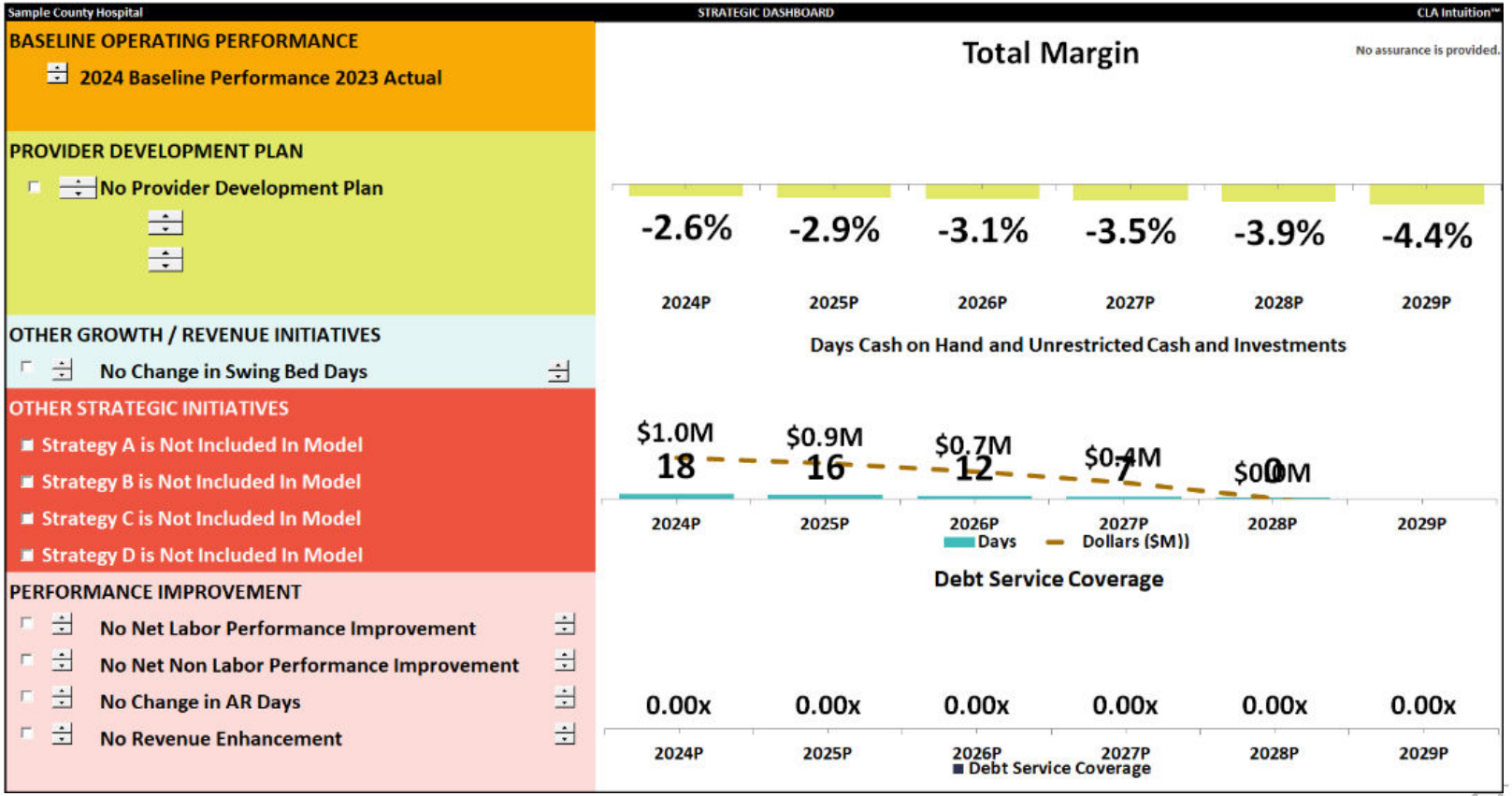
Understandable & Relevant Insights for CEO / Board / Management

Strategic Planning Process

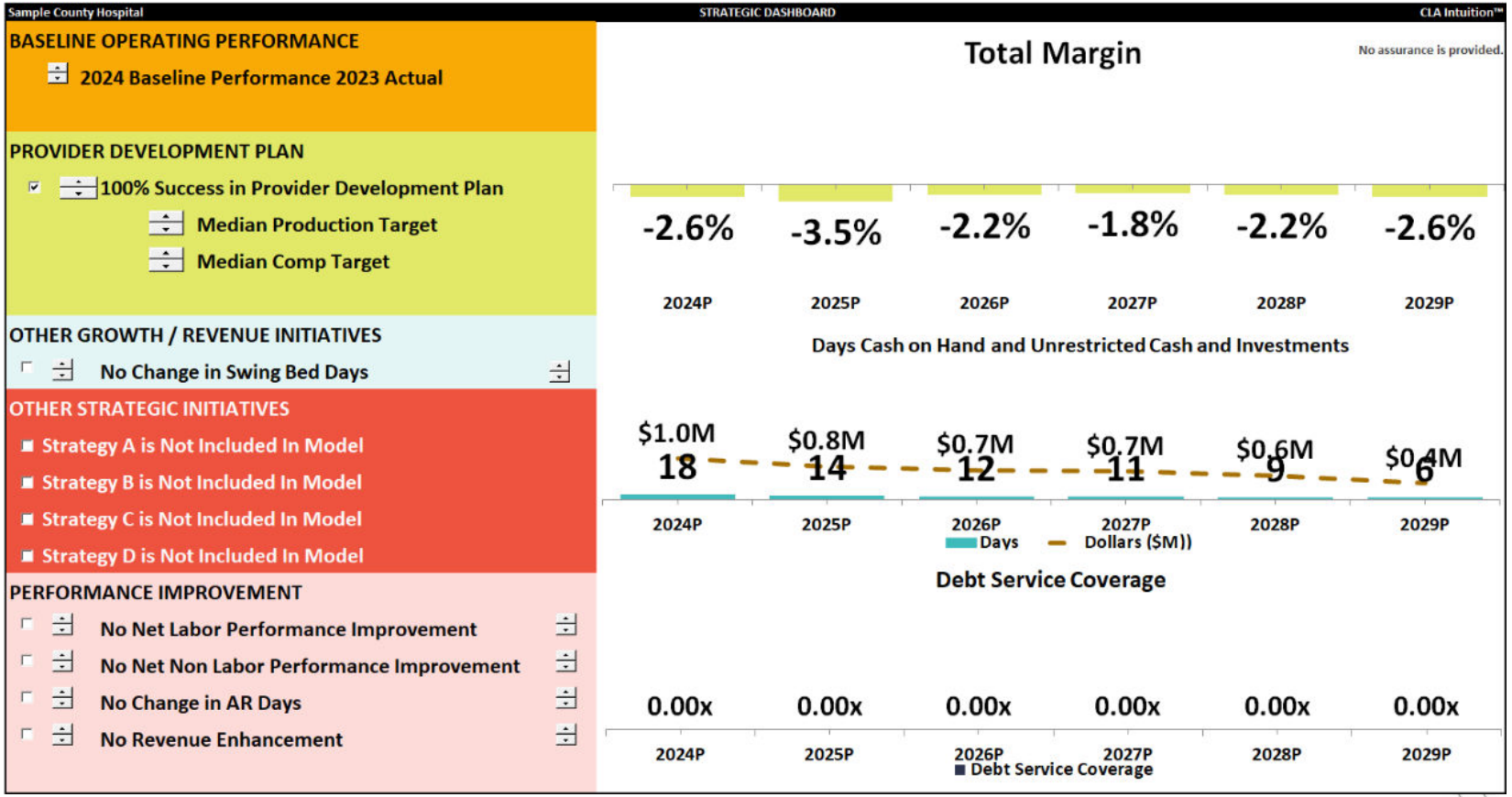
Growth Strategies + Performance Improvements

- Acquire Physicians
- Increase Swing Bed Census
- Costs Savings
- AR Reductions
- (Hopefully Future Capital Projects)

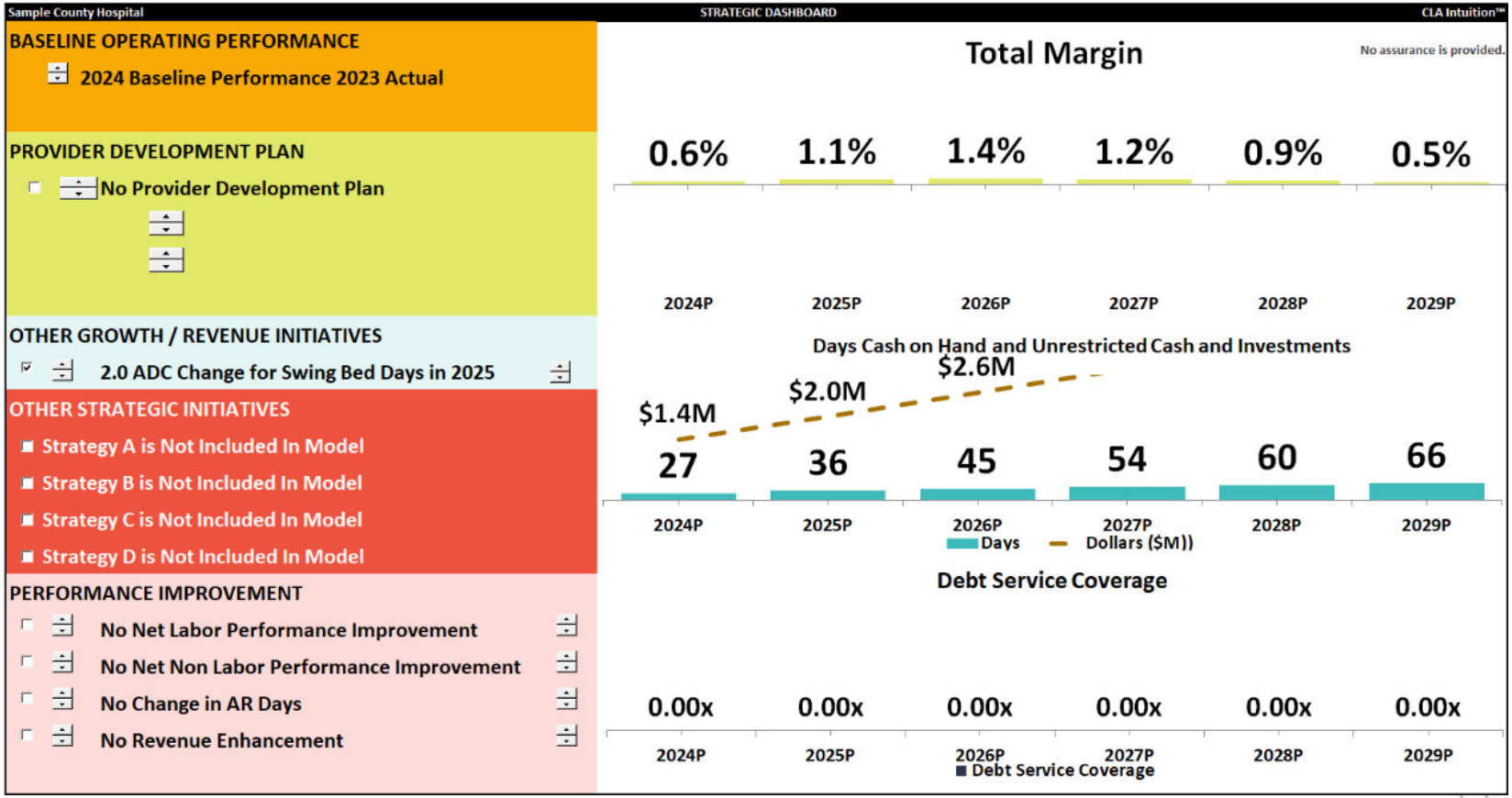
Baseline (and failure to address future)



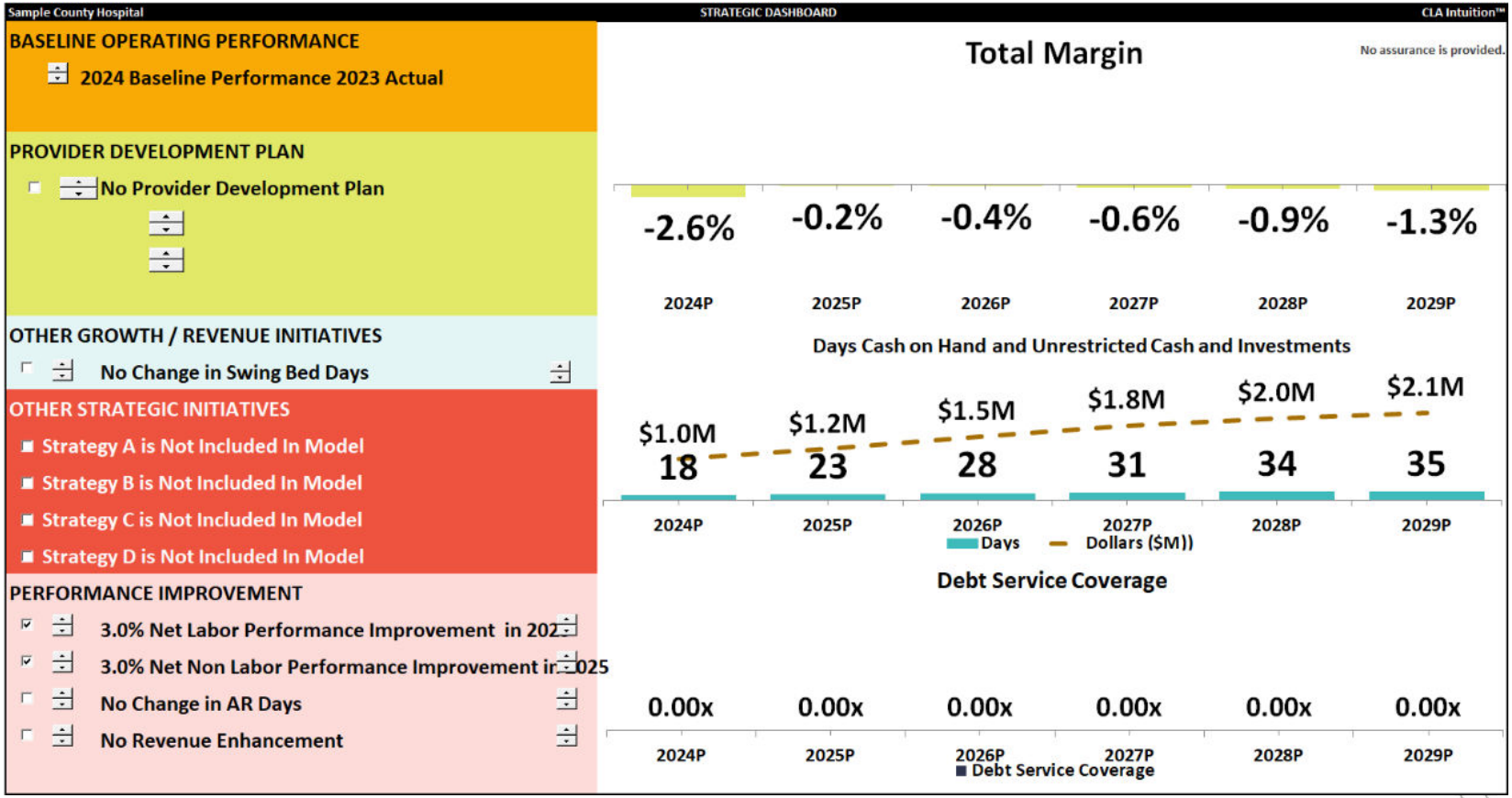
Provider Development Plan



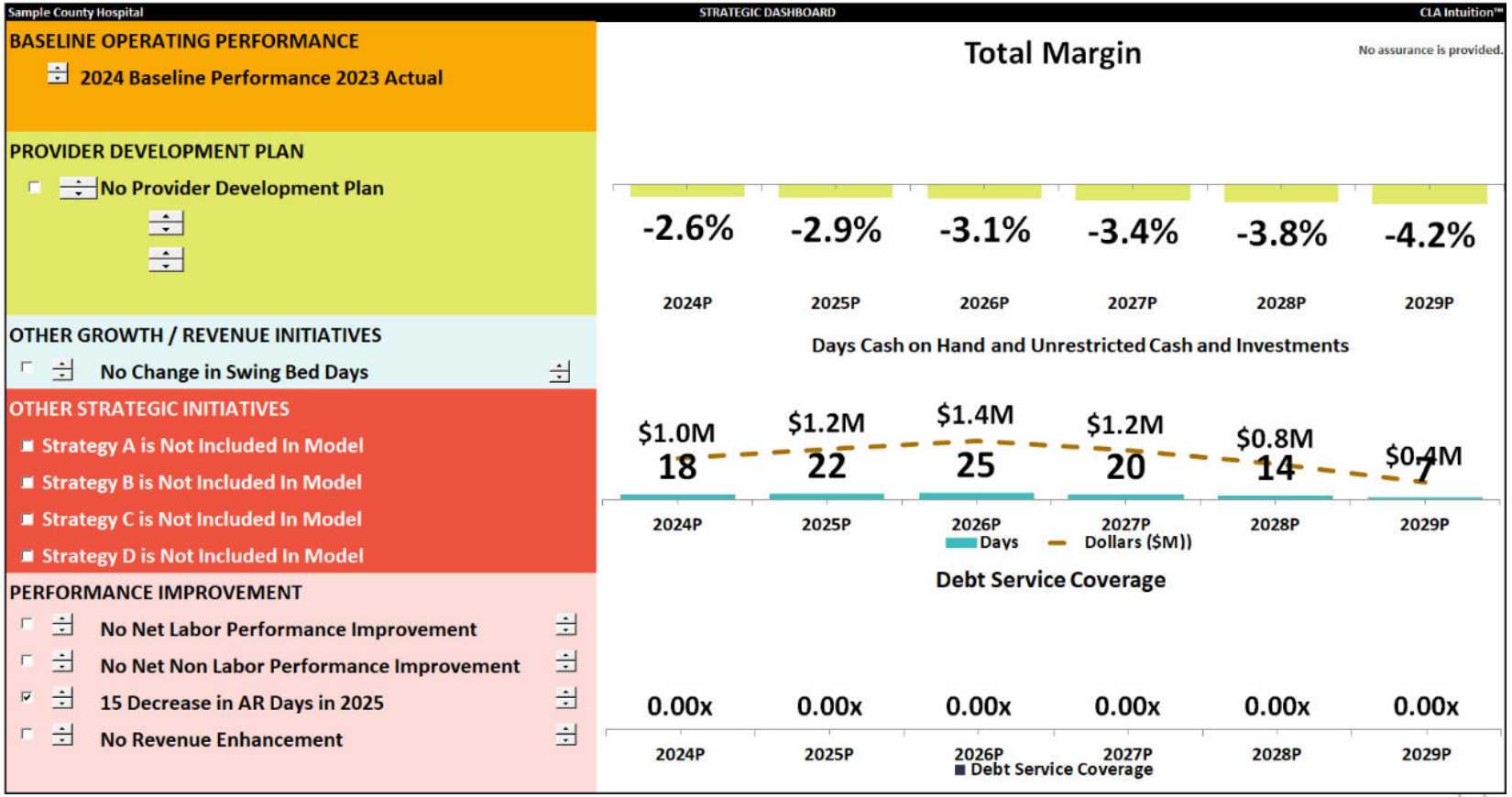
Swing Bed Days



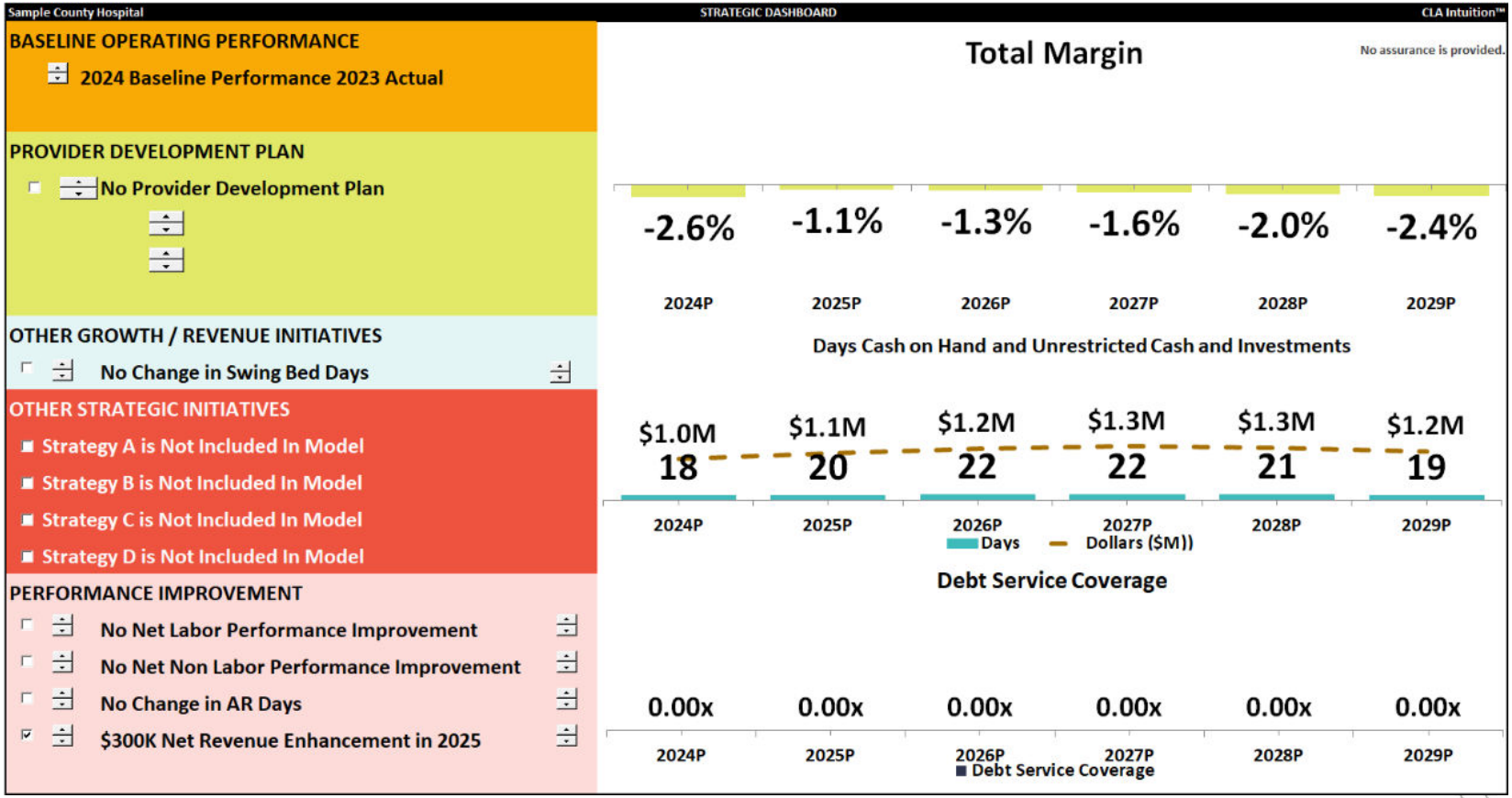
Performance Savings



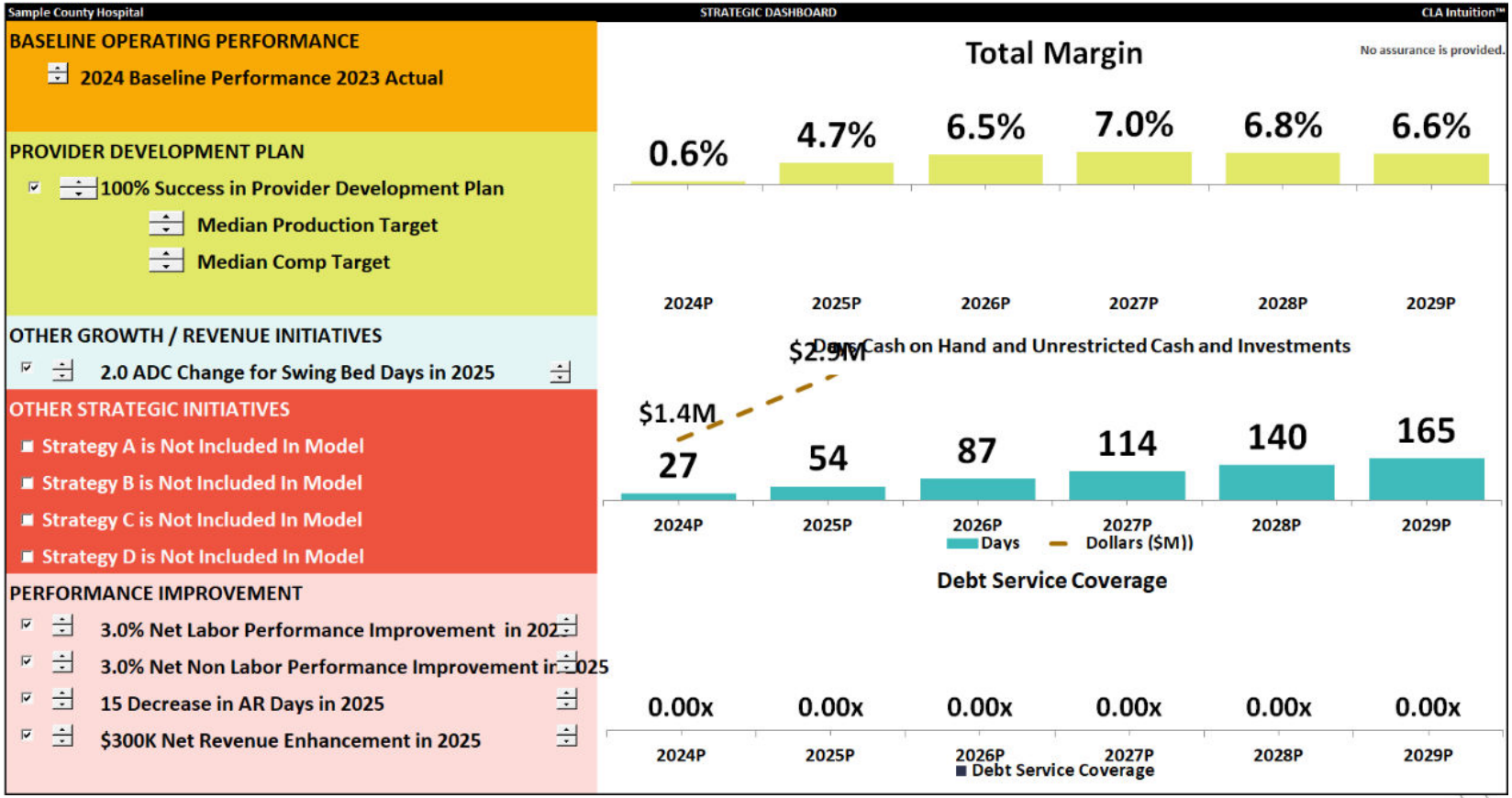
AR Days Reduction



Chargemaster Revenue Improvement



All Strategies at 100%



Profitability Insights

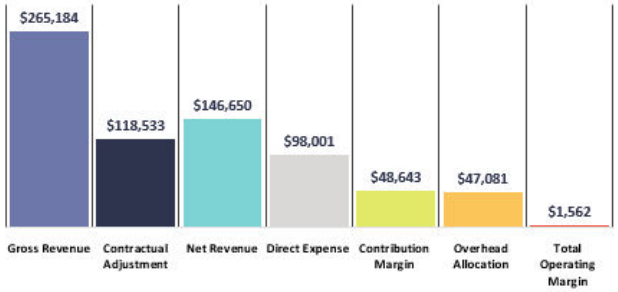
Sample Case Studies

Hospital Service Line Profitability

Physician Practice

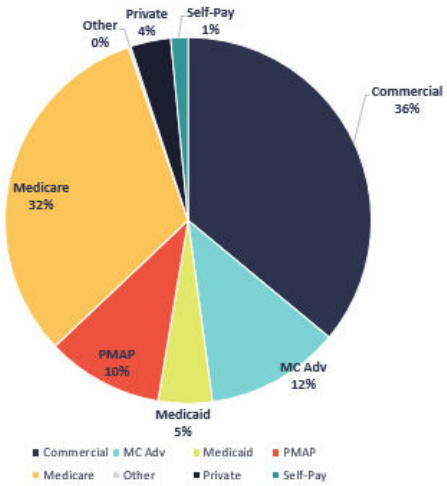
Senior Living & Care

Profitability ($000s)



Payor Mix

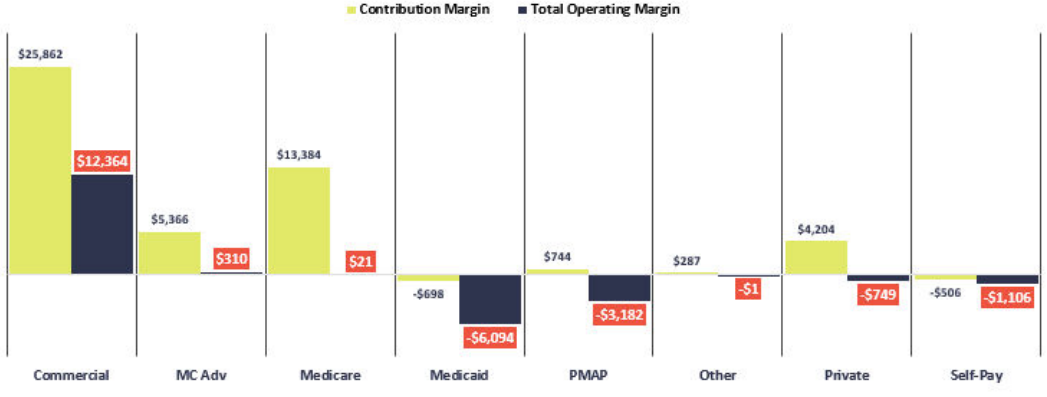
(Gross)



Profitability by Care Site ($000s)

($ In Thousands)	Hospital - Inpatient	Hospital - Outpatient	Clinic	LTC
Gross Revenue	$65,862	$143,406	$55,019	$889
Contractual Adjustment	$19,748	$65,508	$33,139	$139
Net Revenue	$46,114	$77,899	$21,880	$750
Direct Expense	$30,425	$43,844	$23,256	$477
Contribution Margin	**$15,690**	**$34,055**	**-$1,376**	**$274**
Overhead Allocation	$19,956	$19,602	$7,399	$124
Total Operating Margin	**-$4,267**	**$14,453**	**-$8,775**	**$150**

Margin by Payor ($000s)



Select Service(s)	Select Patient Type(s)	Select Payer Class(es)	Select Attributed Location(s)	Select City(s)	Select Year(s)
All	All	All	All	All	All

Pro Forma Costing Breakdown

	2021		2020	
	% of Net	Amount $	% of Net	Amount $
Net Revenue	**100%**	**$126,021,637**	**100%**	**$119,808,925**
Direct Expenses	**75%**	**$95,076,874**	**80%**	**$95,809,537**
Capital Expenses	2%	$3,091,219	3%	$3,306,145
Labor	26%	$32,642,150	28%	$33,637,015
MD Fees	22%	$27,525,087	24%	$29,304,228
Supplies	25%	$31,818,418	25%	$29,562,149
Contribution Margin	**25%**	**$30,944,763**	**20%**	**$23,999,388**
Indirect Expenses	**25%**	**$31,715,806**	**27%**	**$32,857,907**
Capital Expenses	1%	$800,485	2%	$1,974,619
Other Expenses	25%	$30,915,321	26%	$30,883,289
Operating Margin	**-1%**	**($771,043)**	**-7%**	**($8,858,519)**

Net Revenue by Payer

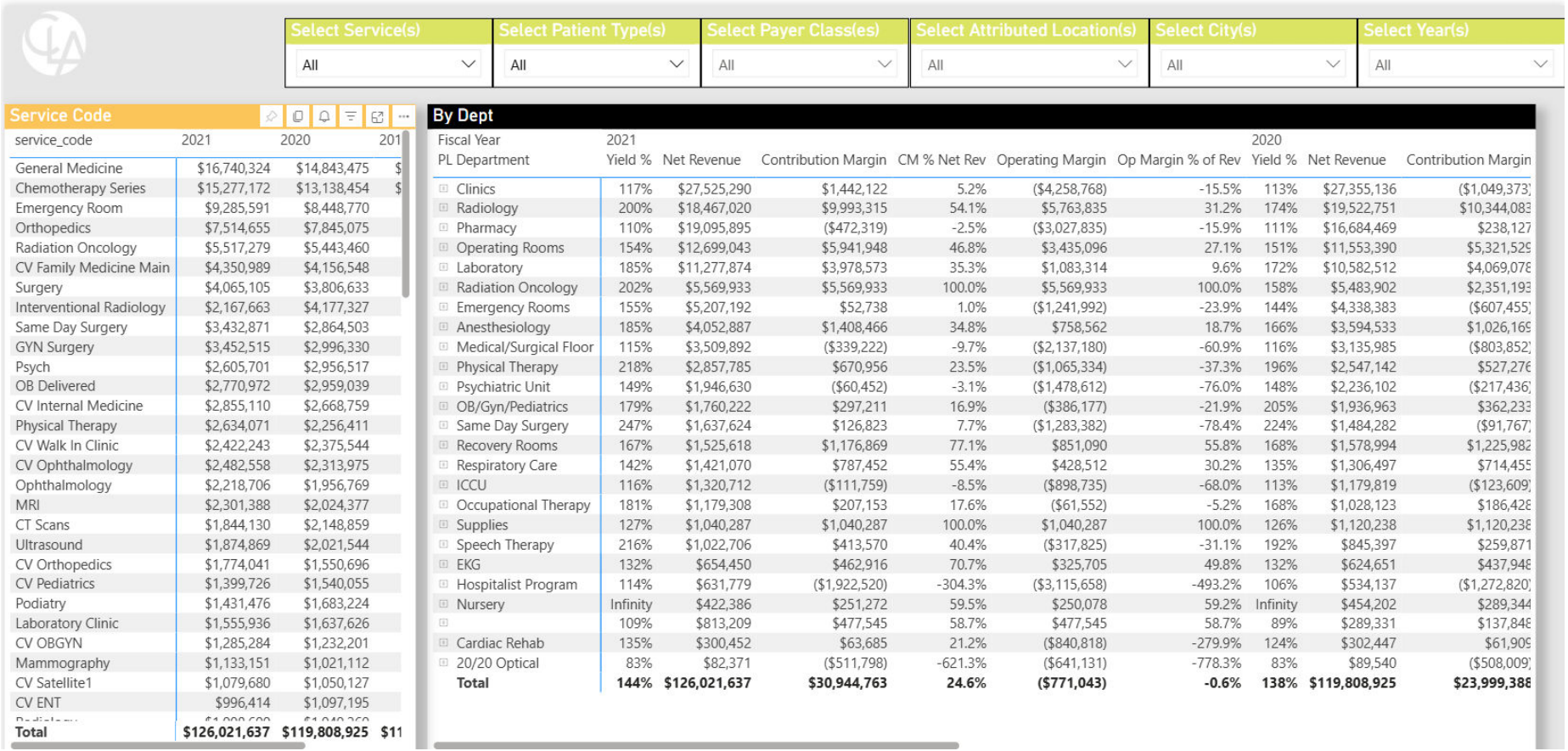
PayorClass	2021	2020	201
Other Commercial	$31,060,153	$29,023,024	
Medicare	$27,227,933	$28,063,690	
Commercial1	$27,598,716	$26,986,743	
Medicare Replacement	$21,261,729	$19,120,278	
Medicaid HMO	$10,893,029	$9,692,651	
Other Government	$2,419,364	$1,466,797	
Medicaid	$1,206,791	$1,573,463	
Self Pay	$1,435,735	$1,256,723	
Workers Comp	$1,079,316	$1,070,864	
Auto/Liability	$729,400	$573,823	
Business Self Pay	$572,157	$502,258	
Total	**$126,021,637**	**$119,808,925**	**$1**

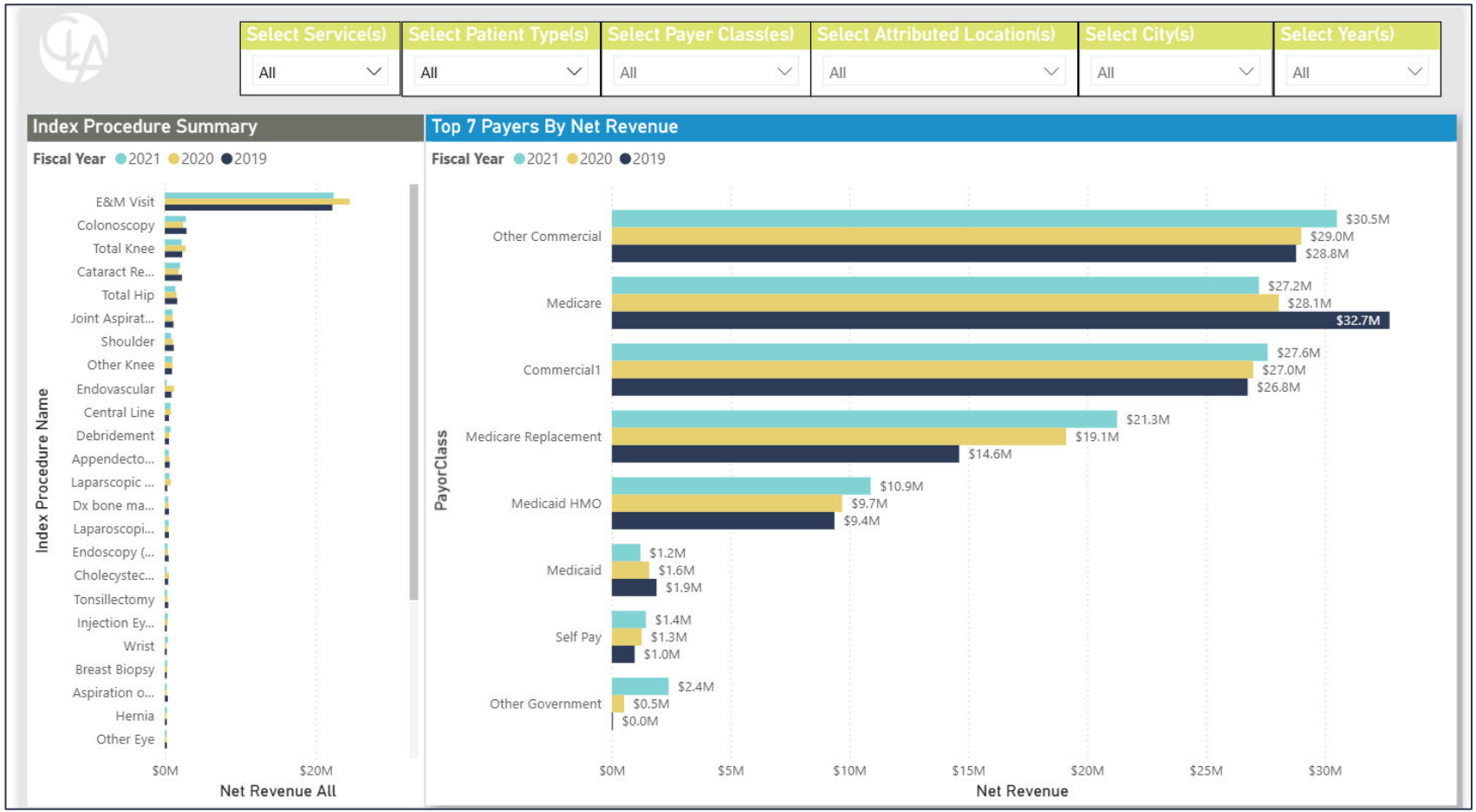
Net Revenue by Patient Type

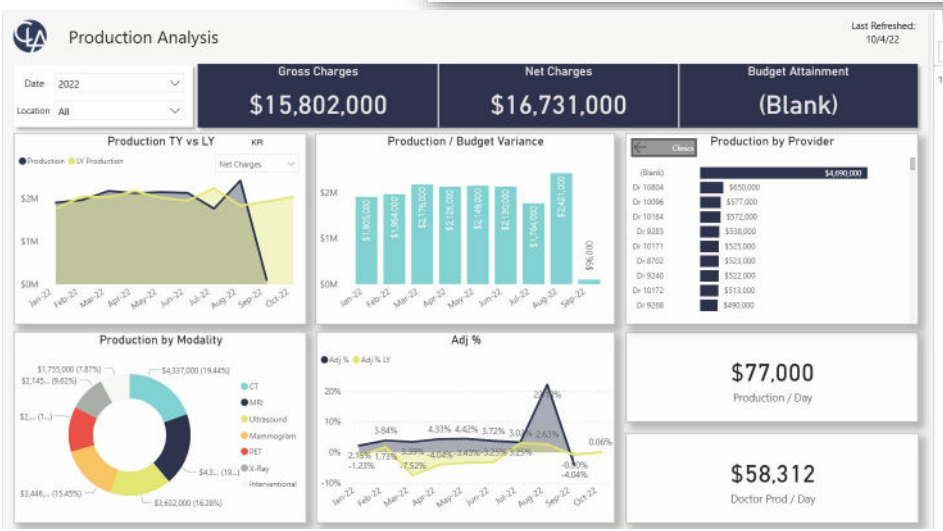
patient_type	2021	2020	20
OP	$59,705,932	$55,568,481	
Clinic Visit	$27,618,474	$26,424,221	
IP Acute	$22,046,371	$21,445,687	
ED	$9,287,270	$8,432,113	
Observation	$3,322,537	$3,387,524	
Psych	$2,605,701	$2,956,517	
Interpretation by Physician	$672,498	$785,037	
On Location Visit	$364,310	$408,174	
Non Patient	$398,544	$401,171	
Total	**$126,021,637**	**$119,808,925**	**$1**

Net Revenue by Servic

service_code	2021	2020	2019
General Medicine	$16,740,324	$14,843,475	$1
Chemotherapy Series	$15,277,172	$13,138,454	$1
Emergency Room	$9,285,591	$8,448,770	$
Orthopedics	$7,514,655	$7,845,075	$
Radiation Oncology	$5,517,279	$5,443,460	$
CV Family Medicine Main	$4,350,989	$4,156,548	$
Surgery	$4,065,105	$3,806,633	$
Interventional Radiology	$2,167,663	$4,177,327	$
Same Day Surgery	$3,432,871	$2,864,503	$
GYN Surgery	$3,452,515	$2,996,330	$
Psych	$2,605,701	$2,956,517	$
OB Delivered	$2,770,972	$2,959,039	$
CV Internal Medicine	$2,855,110	$2,668,759	$
Physical Therapy	$2,634,071	$2,256,411	$
CV Walk In Clinic	$2,422,243	$2,375,544	$
CV Ophthalmology	$2,482,558	$2,313,975	$
Ophthalmology	$2,218,706	$1,956,769	$
MRI	$2,301,388	$2,024,377	$
Total	**$126,021,637**	**$119,808,925**	**$11**





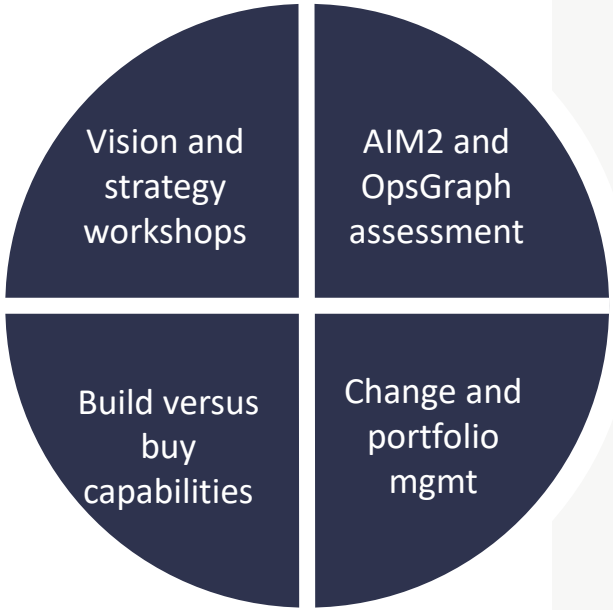


Where to start your transformation journey

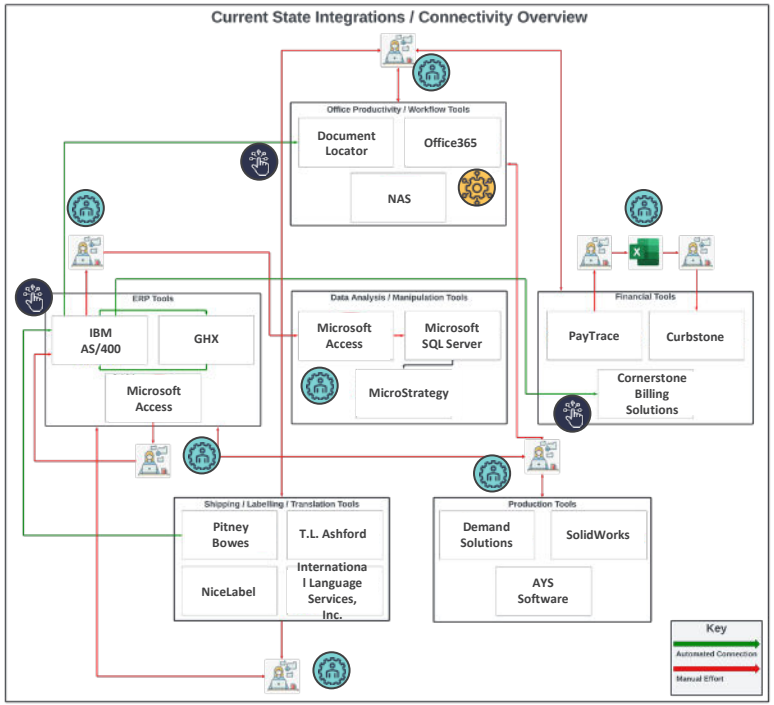
Common Challenges

- Limited visibility across service lines and locations
- High AP volume and manual invoice processing
- Fragmented EMR and back-office integrations
- Legacy on-prem systems Limit growth and flexibility
- Slow month-end close and heavy spreadsheet dependence

Building Your Digital Roadmap



Example: Digital Current State Overview



Limited systems integrations

- Several core systems have existing integrations in place facilitating streamlined workflows
- Still opportunity to enhance integrations to support optimal workflows
- Optimizing ERP platform will reduce much complexity and cost

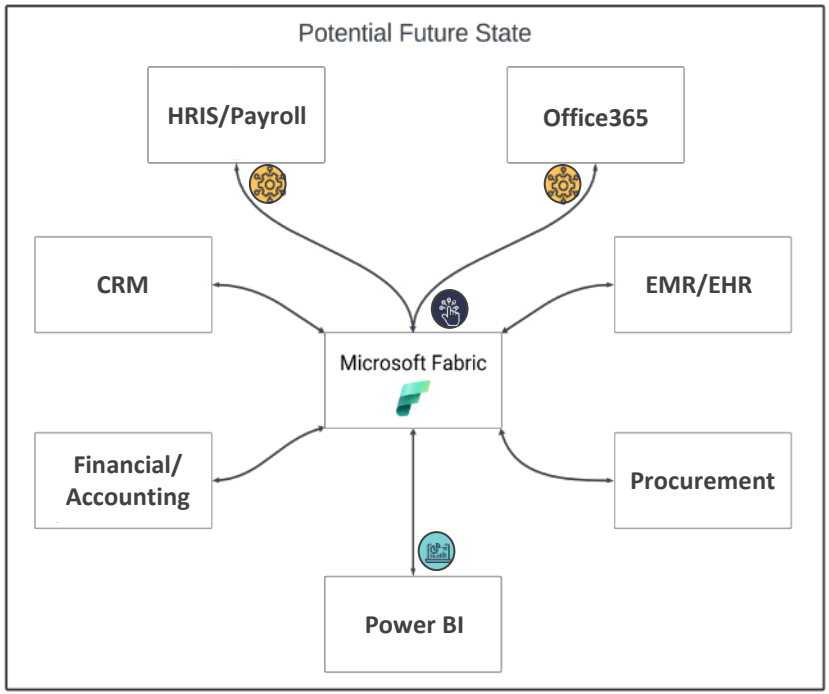
Manual effort and data manipulation required

- Numerous observed points of required manual data extraction / manipulation that can potentially be automated / streamlined
- Credit card strategies require manual exports from 1 system and upload to another

Office productivity platforms represent consolidation opportunity

- Office 365 represents opportunity to consolidate document storage, workflow management, internal file sharing / collaboration and knowledge management repository and analytics approaches into single platform

Example: Potential Future State



Scalable systems integration and connectivity

- Centralized data repository provides opportunity for far wider systems integration, multi-directional data transfer, conditional workflow driven logic and broader automation support to facilitate efficiency

Automated insights and operational reporting

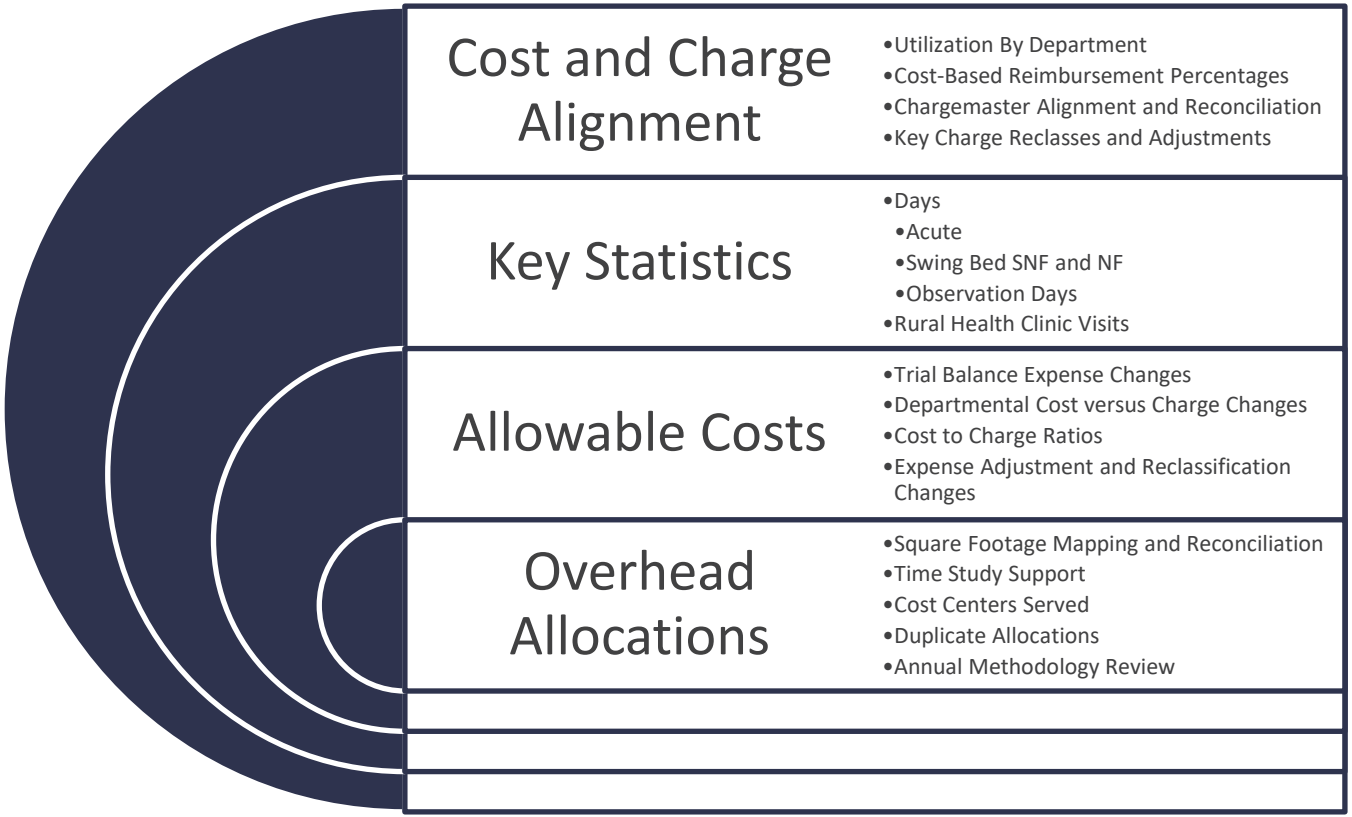
- Scheduled refresh capabilities will provide access to more timely insights while minimizing effort required to derive insights
- Custom tailored reports / visuals will support specific teams, departments and organizational functions with KPIs needed to drive performance

Redundant systems eliminated

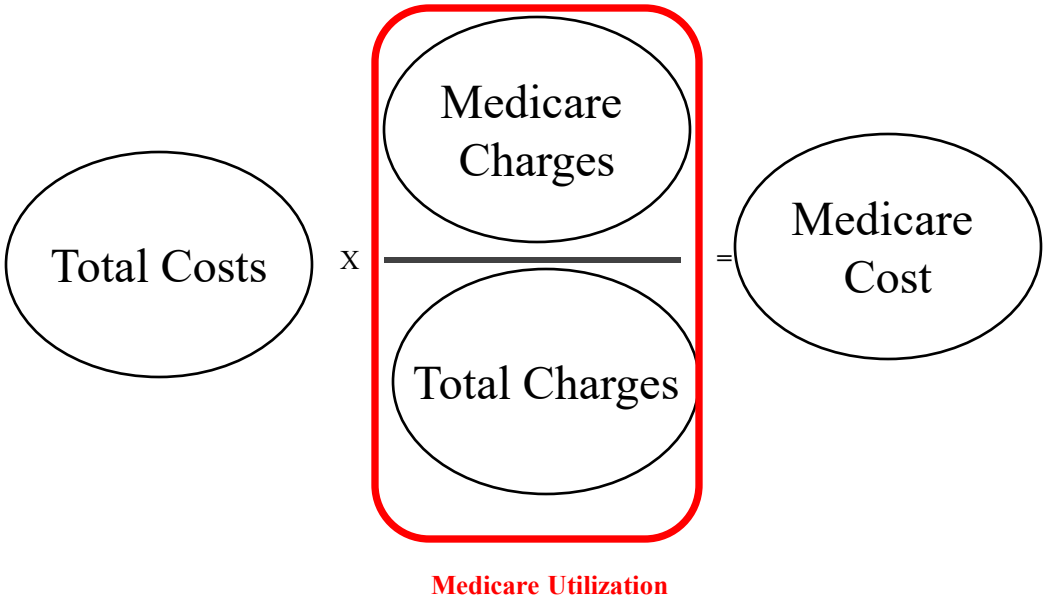
- Fewer core platforms required to operate effectively

Utilizing a Reimbursement Dashboard Approach to “Show You the Money”

Reimbursement Dashboard Ideas



Understanding Your Medicare Cost Report



Medicare Utilization By Department

Inpatient and Outpatient Charges

Medicare Line	Description	Current Year Total Charges	Current Year Medicare Charges	Current Year Medicare Utilization %
50	OPERATING ROOM	9,027,848	3,723,697	41%
52	DELIVERY ROOM & LABOR ROOM	840,606	2,555	0%
53	ANESTHESIOLOGY	937,378	358,408	38%
54	RADIOLOGY-DIAGNOSTIC	11,658,571	4,176,272	36%
60	LABORATORY	12,251,298	4,477,092	37%
65	RESPIRATORY THERAPY	2,581,917	1,397,956	54%
66	PHYSICAL THERAPY	2,335,984	1,085,992	46%
67	OCCUPATIONAL THERAPY	486,365	227,488	47%
68	SPEECH PATHOLOGY	46,864	18,140	39%
69	ELECTROCARDIOLOGY	351,733	196,843	56%
71	MEDICAL SUPPLIES CHARGED TO PAT	4,819,271	2,215,023	46%
73	DRUGS CHARGED TO PATIENTS	8,624,714	4,504,489	52%
76	OP GERI PSYCH	659,802	649,533	98%
90	PROVIDER BASED PHYS. CLINIC #1	258,436	36,239	14%
90.01	PROVIDER BASED PHYS. CLINIC #2	4,325,184	668,450	15%
91	EMERGENCY	4,928,178	1,334,159	27%
92	OBSERVATION BEDS (NON-DISTINCT	1,034,536	352,515	34%

Cost-Based Reimbursement Percentages

Medicare Line	Medicare Cost Center Description	Impact of adding $1000 to Cost Center	Cost Based Reimbursement Percentage
1	CAP REL COSTS-BLDG & FIXT	$ 225	22.50%
1.01	BUILDING ADDITION	$ 473	47.30%
2	CAP REL COSTS-MVBLE EQUIP	$ 314	31.40%
4	EMPLOYEE BENEFITS DEPARTMENT	$ 243	24.30%
5.01	ADMIN & GENERAL	$ 324	32.40%
5.02	BUSINESS OFFICE	$ 351	35.10%
6	MAINTENANCE & REPAIRS	$ 274	27.40%
7	OPERATION OF PLANT	$ 319	31.90%
8	LAUNDRY & LINEN SERVICE	$ 341	34.10%
9	HOUSEKEEPING	$ 313	31.30%
10	DIETARY	$ 289	28.90%
11.1	EMPLOYEE CAFETERIA	$ 257	25.70%
13	NURSING ADMINISTRATION	$ 394	39.40%
14	CENTRAL SERVICES & SUPPLY	$ 456	45.60%
16	MEDICAL RECORDS & LIBRARY	$ 348	34.80%
30	ADULTS & PEDIATRICS	$ 581	58.10%
31	INTENSIVE CARE UNIT	$ 462	46.20%
50	OPERATING ROOM	$ 409	40.90%
52	DELIVERY ROOM & LABOR ROOM	$ (32)	-3.20%
53	ANESTHESIOLOGY	$ 390	39.00%

Cost-Based Reimbursement Percentages

Medicare Line	Medicare Cost Center Description	Impact of adding $1000 to Cost Center	Cost Based Reimbursement Percentage
54	RADIOLOGY-DIAGNOSTIC	$ 347	34.70%
60	LABORATORY	$ 356	35.60%
65	RESPIRATORY THERAPY	$ 544	54.40%
66	PHYSICAL THERAPY	$ 462	46.20%
67	OCCUPATIONAL THERAPY	$ 467	46.70%
68	SPEECH PATHOLOGY	$ 380	38.00%
69	ELECTROCARDIOLOGY	$ 564	56.40%
71	MEDICAL SUPPLIES CHARGED TO PATIENT	$ 456	45.60%
73	DRUGS CHARGED TO PATIENTS	$ 523	52.30%
76	OP GERI PSYCH	$ 1,017	101.70%
90	PROVIDER BASED PHYS. CLINIC #1	$ 155	15.50%
90.2	PROVIDER BASED PHYS. CLINIC #2	$ 131	13.10%
91	EMERGENCY	$ 253	25.30%
95	AMBULANCE SERVICES	$ (35)	-3.50%
101	HOME HEALTH AGENCY	$ (35)	-3.50%
116	HOSPICE	$ (35)	-3.50%
190	GIFT FLOWER COFFEE SHOP & CAN	$ (35)	-3.50%
192	PHYSICIANS PRIVATE OFFICES	$ (35)	-3.50%
194	GUEST MEALS & MOW	$ (35)	-3.50%
194.2	OTHER NRCC	$ (35)	-3.50%

Chargemaster Alignment

- Best Practice – Annual validation of chargemaster to Medicare cost report crosswalk
  - Utilizing Revenue Usage by Charge line with revenue code detail
  - Reconcile to Worksheet C charges before adjustments and reclasses
  - Verify all PS&R charges by revenue code are assigned properly
  - Pivot Table works well

- Validation of resulting utilization
  - Run cost-based utilization report during and after preparation to assure utilization appears accurate

Key Charge Reclasses and Adjustments

- Professional charges
- Drug and Supply Reclasses, including implants
- Observation charges

Cost and Charge Alignment Opportunities/Issues

- Professional charge adjustments
  - Provider-based clinics
  - Hospitalists/Emergency Room/Surgery
- Comparison between departments
    - Family Practice clinics versus Lab/Radiology
    - Operating Room versus Recovery and Anesthesia
- Common alignment issues
  - IV Administrations and Injections – Revenue Code 260
  - IV Solutions – Revenue Code 258
  - Blood Products Versus Blood Administration – Revenue codes 390 and 391
  - Drug charges including imaging contrast
- Observation service alignment options

Real Life Example - Provider Based Clinics

- Example: Data from Filed Medicare Cost Report Worksheet C
- Allowable costs after removal of professional compensation of $313,776

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Title XVIII Therapy Limit Adj.	Title XVIII Total Costs
			1.00	2.00	3.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0		0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0
90.00	09000	CLINIC	313,776		313,776
91.00	09100	EMERGENCY	4,828,085		4,828,085
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,202,950		1,202,950

Real Life Example - Provider Based Clinics

- Reported Charges from Worksheet C

	Cost Center Description		Title XVIII Charges Inpatient	Outpatient	Total (col. 6 + col. 7)
			6.00	7.00	8.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
90.00	09000	CLINIC	381	198,647	199,028
91.00	09100	EMERGENCY	22,625	6,334,681	6,357,306
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	623,449	623,449

- Medicare charges from Worksheet D,V

	Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Title XVIII Hospital Charges PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
			1.00	2.00	3.00	4.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC				
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				
90.00	09000	CLINIC	1.576542	0	0	0
91.00	09100	EMERGENCY	0.759455	0	1,183,514	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.929508	0	317,987	0

Indicated 0% Medicare Utilization. Therefore, no costs covered.

Real Life Example - Provider Based Clinics

- Worksheet C Professional charge calculation for Provider Based Clinics
  - Provider professional cost needs to be removed from the cost report as they are paid based on a fee schedule
  - Professional portion of all charges need to be removed from the Medicare cost report
  - Typically, only Medicare, Medicare advantage, and in some states Medicaid are split-billed when the patient is billed.
    - Medicare Example:

      Charges were split 80% Professional and 20% Technical

      CPT Code 99283 $160 billed as Professional – Show as 983 revenue code in revenue usage

      CPT Code 99283 $40 billed as Technical – Show as 510 revenue code in revenue usage
  - All other payers are billed globally on a 1500 form. However, for Medicare purposes, the professional portion of these charges needs to be calculated and removed from the Medicare cost report.
    - Other Payer Example

      CPT Code 99283 $200 billed globally – Shows as 983 revenue code in revenue usage

      NEED TO IMPUTE CALCULATION OF PROFESSIONAL AND TECHNICAL PORTIONS

Real Life Example - Provider Based Clinics

- Worksheet C Professional charge calculation for Provider Based Clinics (Continued)
  - Need to look at other charges that are 100% Technical such as nursing injections, nursing treatments, supplies, drugs or others.
  - Need to determine which charges are 100% professional and never split regardless of the payer.
  - Example Calculation Below:

Revenue Code	Tech Only	Need to Split	Pro Fee Only	Total
761	$ 34,551	$ -	$ -	$ 34,551
999	$ -	$ -	$ -	$ -
982	$ -	$ 460	$ 24,180	$ 24,640
983	$ -	$ 159,099	$ -	$ 159,099
402	$ 1,181	$ -	$ -	$ 1,181
510	$ 2,174	$ -	$ -	$ 2,174
	$ 37,906	$ 159,559	$ 24,180	$ 221,645
Spread Variance	$ (3,868)	$ (16,282)	$ (2,467)	$ (22,617)
Balance Per General Ledger	$ 34,038	$ 143,277	$ 21,713	$ 199,028
Technical Percentage*	100%	20%	20%	
Calculated Technical Charges	$ 34,038	$ 28,655	$ 4,343	$ 67,036
Professional Charges to Remove from Worksheet C, Line 90				$ 131,992

Real Life Example - Provider Based Clinic

- Needed to review PS&R alignment and make sure all Medicare charges from each applicable revenue code is assigned to each clinic line
  - Due to typical high cost to charge ratios, even smaller amounts of Medicare revenue can be material.
  - Look at all revenue codes generated, typically 510, 771, 260, and others relate to Clinics. Review all revenue by charge line generated by the clinic department. In this case, revenue codes 510 and 761 had Medicare revenue applicable to the clinic in the previous example.
    - Revenue code 761 had been incorrectly aligned with the Emergency Room cost center
    - Revenue Code 510 had been incorrectly aligned with the Operating Room cost center
- After all required corrections Medicare utilization for the clinic was 33%, and an additional $90K per year was realized in increased reimbursement.

Real Life Example - Provider Based Clinics

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Key Statistics

- Validation of Patient Days
  - Reconcile to Revenue Usage Reports
  - Patient Logs – Watch dates
- Swing Bed days – SNF versus NF
  - Significant Area of Opportunities and Risks Recently

Line 5--Enter the Medicare covered swing-bed days (which are considered synonymous with SNF swing-bed days) for all Title XVIII programs where applicable. (See 42 CFR 413.53(a)(2).) Exclude all MA days from column 6, include the MA days in column 8.

Line 6--Enter the non-Medicare covered swing-bed days (which are considered synonymous with NF swing-bed days) for all programs where applicable. (See 42 CFR 413.53(a)(2).)

- Labor and Delivery Days
  - Also address square footage and costs for L&D and Nursery

Key Statistics - Real Life Example

- Review S-3,I to assure that Swing Bed NF days are properly carved out.

	Component	I/P Days / O/P Visits / Trips		
		Title XVIII	Title XIX	Total All Patients
		6.00	7.00	8.00
	PART I - STATISTICAL DATA			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	74	0	83
2.00	HMO and other (see instructions)	0	0	
3.00	HMO IPF Subprovider	0	0	
4.00	HMO IRF Subprovider	0	0	
5.00	Hospital Adults & Peds. Swing Bed SNF	215	0	234
6.00	Hospital Adults & Peds. Swing Bed NF		0	29
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	289	0	346

- Properly breaking out the 29 commercial Swing Bed days above increased reimbursement by approximately $94,000

Key Statistics - Real Life Example

- Caution: Be sure to report Medicare Advantage Days

	Component	I/P Days / O/P Visits / Trips		
		Title XVIII	Title XIX	Total All Patients
		6.00	7.00	8.00
	PART I - STATISTICAL DATA			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	214	0	465
2.00	HMO and other (see instructions)	88	0	
3.00	HMO IPF Subprovider	0	0	
4.00	HMO IRF Subprovider	0	0	
5.00	Hospital Adults & Peds. Swing Bed SNF	256	0	256
6.00	Hospital Adults & Peds. Swing Bed NF		0	266
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	470	0	987

- Unfortunately, Medicare Advantage Days above were reported on the NF Line, causing a potential $230K payback

Key Statistics – Observation Days

- Equivalent Observation Days based on total observation hours divided by 24 to convert to days
- Only pick up base charge if it is considered an hour
- Recent reports revealed that some incorrectly utilized use of number of observation patients instead of days
- Recommend reconciliation to revenue usage report for hours charged
- Dashboard should include comparison of observation days year over year versus observation charges

Key Statistics – Rural Health Clinic Visits

- RHC visits versus inpatient consults, emergency room visits, and other fee schedule visits such as telemedicine
- Face to Face with provider, exclude nurse only
- If over the cost per visit limits, don’t forget Medicaid and other impacts
- Dashboard should include comparison of year over year visits as well as Medicare percentage of visits

Allowable Costs – Trial Balance Expense Changes

- Document significant account balance changes
- Get additional detail for large changes in expenses, other revenues, etc.
- Watch for new professional expense accounts
- How they get assigned this year will impact the future
- Maintain comments and notes for future years and for Medicare audit support
- Dashboard should include significant account balance changes

Departmental Cost Versus Charge Changes

- Monitor cost to charge ratio changes year to year
- Low volume departments can fluctuate due to fixed costs
- Understand expected impact of pricing changes versus volume changes
- Document significant changes for Medicare audit support
- Validate Medicare utilization when there are significant changes
- Get additional detail for large changes in expenses, other revenues, etc.
  - For other revenues, do we need to offset these amounts?

Common Expense Adjustment Mistakes

- Allowable Advertising Costs
- Allowable Physician Recruitment Expenses
- Offset of Miscellaneous Income without any related expense
- Marketing Departments, Community Development, etc.
- Medical Director Costs

- Allowable Advertising Costs
  - 2136.ADVERTISING COSTS--GENERAL
  - The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing covered services to Medicare beneficiaries by providers of services. In determining the allowability of these costs, the intermediary should consider the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.
  - 2l36.l Allowable Advertising Costs.--Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category (see § 2l36.2).
  - Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.
  - Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.
  - Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset
    (see Chapter l, §l04.l0).

- # Allowable Advertising Costs (continued)
  - Costs of advertising incurred in connection with bond issues for which the proceeds are designated for purposes related to patient care, i.e., construction of new facilities or improvements to existing facilities, should be included in "bond expenses" and prorated over the life of the bonds.
  - Costs of activities involving professional contacts with physicians, hospitals, public health agencies, nurses' associations, State and county medical societies, and similar groups and institutions, to apprise them of the availability of the provider's covered services are allowable. Such contacts make known what facilities are available to persons who require such information in providing for patient care, and serve other purposes related to patient care, e.g., exchange of medical information on patients in the provider's facility, administrative and medical policy, utilization review, etc. Similarly, reasonable production and distribution costs of informational materials to professional groups and associations, such as those listed above, are allowable if the materials primarily refer to the provider's operations or contain data on the number and types of patients served. Such materials should contribute to an understanding of the role and function of the facility as a provider of covered health care in the community.
  - Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.
  - Costs of advertising for any purpose not specified above or not excluded below may be allowable if they are related to patient care and are reasonable.

- # Allowable Advertising Costs (continued)
  - 2I36.2 Unallowable Advertising Costs –
  - Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.
  - Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff.
  - Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.
  - Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the Health Care Financing Administration and other Federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients.

Expense Adjustments and Reclassifications

- Year to Year comparison of both adjustments and reclassifications
- Challenge material adjustments
  - Why are we offsetting these?
  - Is this adjustment still applicable?
- Do we still need an expense reclass?
  - Did we change the way we are reporting expenses through AJEs or Payroll?

Overhead Allocations – Square Footage

- Dashboard should include review of changes
- Spreadsheet designed by room, by building, by usage assigned to Medicare cost reports for continual updates
- Annually updates and review recommended

Overhead Allocations – Time Study Support

- Dashboard should include review of changes
- Monitoring needed throughout the year
- Understand, challenge, and retain support
- Consider alternatives to avoid manual time studies

Overhead Allocations – Cost Centers Served

- Dashboard should include review of changes
- Overhead costs only need to be allocated to cost centers serving support
- Review job descriptions annually
- Strategies to avoid the need for allocations

Overhead Allocations – Duplicate Allocations

- Some common duplicate allocation costs
  - Phone expenses
  - Receptionist costs
  - Insurance
  - Utilities/Garbage services
  - Housekeeping costs
  - Billing/Software Costs
  - Others
- Don’t forget the space being utilized
- Core opportunities are often in non-reimbursable or low utilized departments

Real Life Example – Duplicate Cost Allocations

- Administrative costs directly included on M-1 for RHC, while also allocated to through step down allocations.

					RHC I	Cost	
		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY OVERHEAD						
29.00	Facility Costs	7,067	963	8,030	0	8,030	29.00
30.00	Administrative Costs	273,272	3,059	276,331	0	276,331	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	280,339	4,022	284,361	0	284,361	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	908,116	1,599,852	2,507,968	0	2,507,968	32.00

- Correcting admissions and registration clerks that were confirmed to be located directly in the rural health clinic resulted in additional reimbursement of approximately $36K per year.
- Space costs will increase this impact

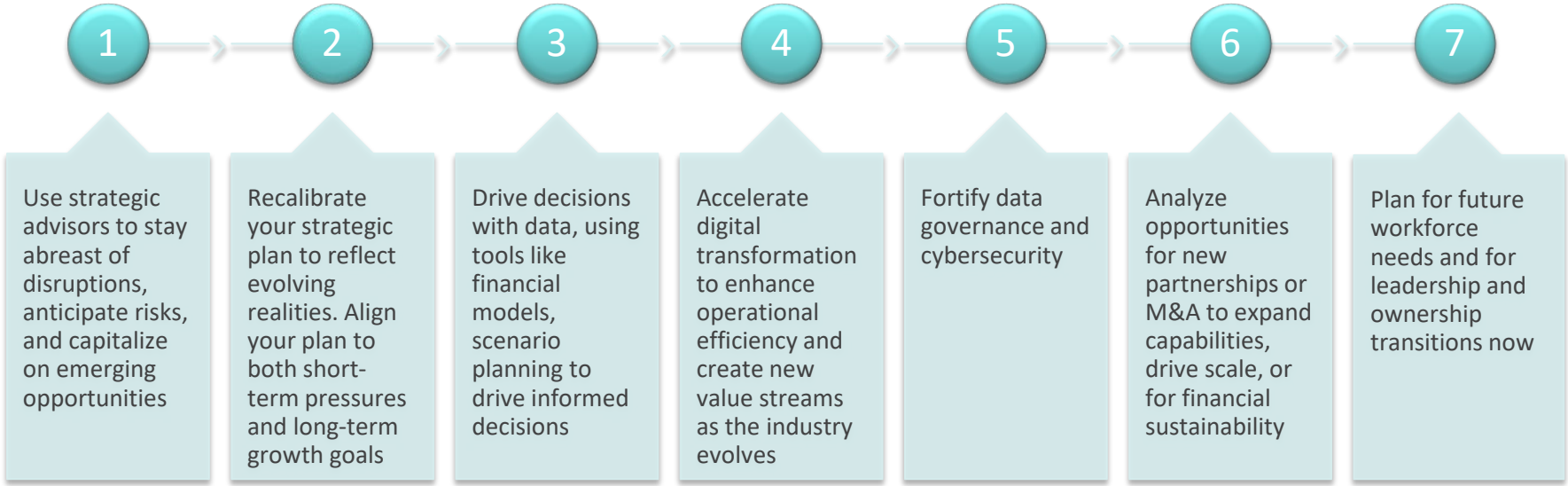
Overhead Allocations – Annual Review

- Componentization of administrative cost centers
- Other overhead statistics
- Are you using all required statistics?
- Dashboard thought
  - Track impact testing annually
  - Impacts can change over time

Discussion and Questions

Closing Thoughts

Call for HCLS is to understand sweeping changes, create plans, execute now to meet the coming decade



Thank you!

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