Methodology

Data Sources
The Colorado Hospital Association (CHA) compiled this report using publicly available data. Financial and utilization data came from the CMS Cost Reports that hospitals file annually. Quality data came from CMS Hospital Compare and the Medicaid Hospital Quality Incentive Program. State and national health expenditure and utilization data came from the CMS Health Expenditures by State of Residence dataset. Licensed beds came from CPDHE, and general hospital information came from the hospitals’ websites. The datasets can be downloaded from:

Cost Reports:

Hospital Compare:
https://data.medicare.gov/data/hospital-compare

HQIP scores:
https://www.colorado.gov/hcpf/hospital-provider-fee-oversight-and-advisory-board

National Health Expenditure:

Licensed Beds:
http://www.hfemsd2.dphe.state.co.us/hfd2003/homebase.aspx?Ftype=hospital&Do=list

CHA downloaded files for this report on July 24th, 2017. As CMS periodically updates both the HCRIS and Hospital Compare files with the most recent data and cost reports, subsequent downloads these databases may vary. Licensed beds are reported as what CDPHE had listed as currently licensed to each facility, and may therefore vary from what a hospital had during any of the past fiscal years included in this report.

This report includes two quality measures: The CMS Overall Hospital Rating and the Medicaid Hospital Quality Incentive Program score. The CMS Overall Hospital Rating is described as follows on Hospital Compare:

The hospital overall ratings are designed to assist patients, consumers, and others in comparing hospitals side-by-side. The hospital overall ratings show the quality of care a hospital may provide compared to other hospitals based on the quality measures reported on Hospital Compare. The hospital overall ratings summarize more than 60 measures reported on Hospital Compare into a single rating. The measures come from the IQR, OQR, and other programs and encompass measures in seven measure groups: mortality, safety of care, readmission, patient
experience, effectiveness of care, timeliness of care, and efficient use of medical imaging. The hospitals can receive between one and five stars, with five stars being the highest rating, and the more stars, the better the hospital performs on the quality measures. Most hospitals will display a three star rating. Reporting Cycle Data collection period will vary by measure, and will be updated bi-annually.

The Medicaid Hospital Quality Incentive Program (HQIP) is administered by the Colorado Department of Health Care Policy and Financing (HCPF). Hospitals are scored in a maximum of five quality measures, which are split between base measures and optional measures. Optional measures are only available if a hospital cannot participate in one of the base measures; for example, a hospital that does not do labor and delivery cannot be scored on a labor and delivery metric. A hospital’s total points awarded are the sum of its base measure points and optional measure points.

The 2017 measures are:

1. **Base Measure Points:** Points awarded based on established scoring criteria for the following measures:
   a. Emergency department process measure;
   b. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position;
   c. Rate of thirty-day all-cause hospital readmissions;
   d. Percentage of patients who gave the hospital an overall rating of “9” or “10” on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey; and
   e. Culture of safety.

2. **Optional Measure Points:** If a Base Measure does not apply, a hospital may substitute an Optional Measure. Optional Measures must be selected in the order listed:
   a. Active participation in a RCCO;
   b. Advance care planning; and
   c. Screening and intervention for tobacco use.

More information is available at the HQIP website:

https://www.colorado.gov/pacific/hcpf/hospital-quality-incentive-payment-program-subcommittee

**Medicare Cost Report Data**

Any facility that receives Medicare payments must complete and submit a Medicare Cost Report, which is a publicly available statement of financial and utilization metrics. These data are audited, but occasionally still contain errors or omissions. The data presented in this report are unaltered from the Cost Reports, and thus also contain the few errors published in the Cost Reports, which occasionally result in incorrect calculations done for the report using these erroneous values. Known errors include:

- Reporting uncompensated care expenses as a negative value (ex: Colorado Mental Health Institute);
- Typos/incorrectly reported available beds (ex: St. Anthony North 2012); and
- Missing values (ex: FTEs and paid hours for several non-CAH hospitals).
Some hospitals changed fiscal years and subsequently submitted an incomplete cost report for a given fiscal year, as the remainder of that year was rolled into the next, newly-defined fiscal year. Values for any hospitals with fewer than 363 days represented in a period are marked with an asterisk. Hospitals to which any quality measure did not apply are marked with “Not Applicable,” while hospitals that did not have enough data to report the measure are marked with “Not Available.” Some facilities are not required to report certain sections of the Cost Report, omitted certain sections for some years (incomplete/incorrect data), or reported zero values; these are marked as “Not Reported.”

### Specific Sources and Calculations of Data from Medicare Cost Reports

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<tr>
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<td>Employees on Payroll FTEs</td>
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<td>Gross Patient Revenue</td>
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<td>Payer Mix</td>
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²For 2012, as a leap year, the formula is [Days in Reporting Period/366]
Details and Definitions on Metrics and Calculations

Employment Trends

**FTEs on Payroll: worksheet S-3, Part 1, Column 10 Line 14**
The average number of FTE employees for the period may be determined either on a quarterly or semiannual basis.

**Total Interns and Residents FTEs: S3 Part 1 Column 9 Line 14**
Number of intern and resident FTEs in an approved program, determined in accordance with 42 CFR 412.105 (f), for the indirect medical education adjustment.

**Total FTEs: S-3, Part II, Column 5, Lines 1, 11-16, 28, 33 & 35 ÷ (2080 * (days in cost report period / total days in fiscal year))**
Total FTEs includes both FTEs on payroll and contract labor FTEs. Total hours from worksheet S-3, Part II, Column 5, Lines 1, 11-16, 28, 33 & 35 are divided by 2080 (or the corrected proportion for incomplete fiscal year cost reports) to equal total FTEs used on the hospital summary. Some hospitals have short cost reporting periods, therefore the denominator will be weighted based off the total days in the cost report period. The number of paid hours correspond to the salary amounts reported in worksheet S-3, part III, column 4. Paid hours include regular hours (including paid lunch hours), overtime hours, paid holiday, vacation and sick leave hours, paid time-off hours and hours associated with severance pay. The source for paid hours on Worksheet S-3, Part II is the provider’s payroll report, and hospitals can have different methodologies for reporting wage index information. Hours are included on the payroll report in the period the associated expense is paid. CAH and some specialty hospitals are not required to completed this section of the cost report, therefore their Total FTEs line will read “Not Reported.”

Utilization Trends

**Available Beds: worksheet S-3, Part 1, column 2 Line 14 plus Line 2**
Number of beds available for use by patient at the end of the cost reporting period. A bed means an adult bed, pediatric bed, portion of inpatient labor/delivery/postpartum (LDP) room (also referred to as birthing room) bed when used for services other than labor and delivery, or newborn ICU bed (excluding newborn bassinets) maintained in a patient care area for lodging patients in acute, long term, or domiciliary areas of the hospital. Beds in post-anesthesia, postoperative recovery rooms, outpatient areas, emergency rooms, ancillary departments (however, see exception for labor and delivery department), nurses’ and other staff residences, and other such areas that are regularly maintained and utilized for only a portion of the stay of patients (primarily for special procedures or not for inpatient lodging) are not termed a bed for these purposes.

**Inpatient Discharges: worksheet S-3 Part 1, column 15 Line 14 plus Line 2**
Number of discharges including deaths (excluding newborn and DOAs) for all classes of patients for each component.

**Inpatient Days: worksheet S-3, Part 1, Column 8 Line 14 plus Line 2**
The number of inpatient days for all classes of patients for each component.

**Average Length of Stay: Inpatient Days divided by Inpatient Discharges:**
In calculating the average length of stay (ALOS), swing beds total days, which are included in S3 Part 1 Column 8 Line 5 and 6, were removed, as swing bed discharges are not reported on the cost report (S3 Part 1 Column 15 Line 14). As swing bed discharges are not reported on the cost report, including swing beds total days would artificially inflate the ALOS calculation.

**Occupancy Rate:** Inpatient Days divided by (Available Beds*365)
Worksheet S-3, Part 1, Column 8 Line 14 plus Line 2 * Days in Reporting Period. This occupancy rate does include swing beds, as they are included in inpatient days, but not days in observation beds.

**Observations Days:** worksheet S-3, Part 1, Column 8 Line 28
Divide the total number of observation bed hours by 24 and round up to the nearest whole day. These total hours should include the hours for observation of patients who are subsequently admitted as inpatients but only the hours up to the time of admission as well as the hours for observation of patients who are not subsequently admitted as inpatients but only the hours up to the time of discharge from the facility. Observation bed days only need to be computed if the observation bed patients are placed in a routine patient care area.

**Calculation and Data Sources of Financial Trends Section**

**What is Net Patient Revenue and Patient Margin?**
Net Patient Revenue is Gross Patient revenue minus contractual allowances and discounts. Patient revenue is revenue that a hospital receives from its core business, treating patients. For this metric, only revenues for patient care services are included. Examples of patient revenues included payments from Medicaid, Medicare, commercial payers and patients. The factors in determining net patient revenue and patient margin are:

- **Gross Revenue:** represents to total gross charges for all services provider by a hospital.
- **Contractual Allowances:** represents the difference between the amount the hospital charges and the amount they have agreed to accept as payments. This may be based on the cost-based rate Medicare will pay, the Medicaid payment rates or contracted amount from commercial insurers.
- **Net Patient Revenue:** The dollar amount a hospital received for patient services; or Gross Revenue less Contractual Allowances.
- **Operating Expenses:** Expense incurred during the ordinary course of operating the hospital complex.
- **Net Income (loss) from Services to patient:** This amount represents a hospital’s net gain or loss on providing services to patients.

Net income (or loss) from services to patient is calculated as: Net Patient Revenue minus Operating Expenses.

- **Patient Service Margin Percent:** represents a ratio comparison of net income (loss) from services to patients compared to net patient revenue. This percentage represent the amount of gain or loss a hospital sees for each dollar of revenue.
Patient service margin percent is calculated as: \[(\text{Net Income from Service to Patients divided by Net Patient Revenue}) \times 100\]

**Example:**

A hospital with net patient revenue of $750,000 and operating expenses of $1 million equals a net loss from Services to Patients of -$250,000. This loss is divided by net patient revenue of $750,000, times 100, or -33 percent. This means this hospital’s net loss from patient services for the period equals 33 percent of hospital revenue. Therefore, this hospital is losing $0.33 for every $1 of net patient revenue.

**Gross Patient Revenue: worksheet G-3, Column 1 Line 1**

Revenue from patient services provided to patients.

**Contractual Allowances: worksheet G-3, Column 1 Line 2**

Allowances and discounts on patient accounts represents total revenues not received. Allowances and discounts include, but are not limited to:

- Provision for Bad Debts,
- Contractual Adjustments,
- Charity Discounts,
- Teaching Allowances,
- Policy Discounts,
- Administrative Adjustments, and
- Other Deductions from Revenue

**Total Operating Expenses: worksheet G-3, Column 1 Line 4**

Expenses incurred that arise during the ordinary course of operating the hospital complex.

**Charity Care: worksheet S-10, Column 3 Line 23**

Health services for which a hospital demonstrates that the patient is unable to pay. Charity care results from a hospital’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria.

**Bad Debt: worksheet, S-10, Column 1 Line 29**

Cost of non-Medicare and non-reimbursement Medicare Bad Debt Expense is calculated as follows:

1. Non-Medicare and Non-reimbursable Medicare bad debts expenses (worksheet S-10, line 26 minus worksheet S 10, Line 27)

   Total facility (entire hospital complex) amount of bad debts written off during the cost reporting period on balances owed by patient regardless of date of service. Includes bad debts for all services except physician and other professional services.

   **LESS:**

   Medicare bad debts for entire hospital complex – total of Medicare reimbursable bad debts included in: Worksheets: E, Part A, line 65; E, Part B, line 35; E-2, line 17, columns 1 and 2 (line 17.01, columns 1 and 2 for cost reporting periods that begin on or after
EQUALS:

Non-Medicare and Non-reimbursable Medicare bad debts expenses (worksheet S-10 Line 28)

2. Cost of non-Medicare and non-reimbursement Medicare Bad Debt Expense (worksheet S-10, line 28 multiplied by worksheet S-10, line 1)

   Non-Medicare and non-reimbursable Medicare bad debt expenses

MULTIPLIED BY

Hospital cost-to-charge Ratio (worksheet S-10, line 1)

EQUALS:

Cost of non-Medicare and non-reimbursement Medicare Bad Debt Expense

Non-Medicare Bad Debt: Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling/unable to settle the claim.

Non-reimbursable Medicare Bad Debt: The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of 42 CFR 413.89(h) and CMS Pub. 15-1, chapter 3.

Salaries and Benefits:

Worksheet A Column 1 Line 200 – (Lines 4 + 12) + (Column 5 Lines 4 + 12) OR worksheet S-3, Part II, Column 4, Lines 1, 11-25, 28, 33 & 35

Through feedback and discussion with Colorado Hospitals, it was determined that the wage index worksheets (worksheet S-3, part II) are the most appropriate place to obtain salary and benefit information. However, the Centers for Medicare and Medicaid (CMS) currently does not require critical access hospitals (CAH) and some specialty hospitals to report wage index information on worksheet S-3, part II. Therefore, benefits and salaries expenses for acute care hospitals will be pulled from worksheet S-3, part II, and from worksheet A for CAHs.

It should be noted, using worksheet A will under-report benefit expenses for CAHs that report benefits allocated by cost center in worksheet A, column 2. In additional to benefits, worksheet A, column 2 also includes cost center expenses and therefore it is not possible to pull out benefits from the cost report.
and therefore expenses reported in column 2 are not being used in the salary and benefits expense amounts.

**Other Non-Patient Revenue: worksheet G-3, Column 1 Line 25**

Revenues reported in hospital accounting books and or records not included in gross patient revenue. Per worksheet G-3, these revenues include:

- Contributions, donations, bequests
- Income from investments
- Revenues from telephone and other miscellaneous communication services
- Revenue from television and radio service
- Purchase discounts
- Rebates and refunds of expenses
- Parking lot receipts
- Revenue from laundry and linen service
- Revenue from meals sold to employees and guests
- Revenue from rental of living quarters
- Revenue from sale of medical and surgical supplies to other than patients
- Revenue from sale of drugs to other than patients
- Revenue from sale of medical records and abstracts
- Tuition (fees, sale of textbooks, uniforms, etc.)
- Revenue from gifts, flowers, coffee shops and canteen
- Rental of vending machines
- Rental of hospital space
- Governmental appropriations
- Other

**Other Non-Patient Expenses: worksheet G-3, Column 1 Line 28**

Other expenses not reported in operating expenses or other components of worksheet G3.

**Total Unreimbursed cost for Medicaid – worksheet S-10, Line 19**

The unreimbursed cost for Medicaid is a comparison of the total Medicaid payment received for services provided compared to the total Medicaid costs of these services. Each hospital calculates Medicaid costs by using total Medicaid charges (worksheet S-10, line 6) multiplied by the hospitals cost to charge ratio (Worksheet S-10, line 1). Total Medicaid cost, calculated above, is compared to the total payment received from Medicaid (worksheet S-10, line 2), which equals the hospitals unreimbursed cost for Medicaid. The same methodology explained for Medicaid is used to calculate unreimbursed costs for State Children’s Health Insurance Program (SCHIP) and for local indigent care program. The unreimbursed costs for Medicaid, SCHIP and indigent care are summed in line 29 and used for this report.

**Total Margin: worksheet G-3, Column 1 Line 29**

Net Income or loss for the cost report period; Total Revenue (net patient revenue plus total non-patient revenues) minus (Total Operating Expenses plus other non-patient expenses).
**Patient Service Margin:** worksheet G-3, Column 1 Line 5 divided by G3 Column 1 Line 3
Net Income from Service to Patients divided by Net Patient Revenue.

**Total Margin Percent:** worksheet G-3, Column 1 Line 29 divided by (Line 3 + Line 25)
Total Margin divided by (Net Patient Revenue plus Other Non-Patient Revenue)

**Total Hospitals Expense (%) in 2015**

Worksheet A is the source for the Total Hospital Expense percent bar graphs included on the hospital summary sheets. The explanation below is broken out into three sections explaining worksheet A reporting requirements and data sources used for each graph data point and the percentage calculation.

**Worksheet A - Reclassification and Adjustment of Trial Balance of Expenses Cost Report Instructions:**

In accordance with 42 CFR 413.20, the methods of determining costs payable under title XVIII involve using data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services. Worksheet A provides for recording the trial balance of expense accounts from your accounting books and records. It also provides for the necessary reclassifications and adjustments to certain accounts.

List on the appropriate lines in columns 1, 2, and 3, the total expenses incurred during the cost reporting period. These expenses are detailed between salaries (column 1) and other than salaries (column 2).

**Column 1**—Report in each cost center only direct salaries and wages plus related salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay. Refer to the instructions at Worksheet S-3, Part II, column 2, line 1, for the definition of bonus pay and PTO salary cost. **NOTE:** Paid vacation, holiday, sick, other PTO, severance, and bonus pay must be reported with related direct salaries or wages in column 1.

**Column 2**—Report in each cost center the cost incurred for contract labor, both wage and wage related contract labor cost, for services contracted by the hospital, the home office, or related organizations. If necessary, reclassify contract labor costs to the cost center benefiting from the contract labor services (see column 4 instructions). In addition, all other costs not reported in column 1 must be reported in column 2.

The sum of columns 1 and 2 equals the sum of column 3. Record any needed reclassifications and/or adjustments in columns 4 and 6, as appropriate.

**Column 4**—Except for the reclassification of capital-related costs which are reclassified via Worksheet A-7, all reclassifications in this column are made via Worksheet A-6. Worksheet A-6 need not be completed by all providers and is completed only to the extent that the reclassifications are needed and
appropriate in each circumstance. Show reductions to expenses as negative numbers. The net total of
the entries in column 4 must equal zero on line 200.

**Column 5**—Adjust the amounts entered in column 3 by the amounts in column 4 (increase or
decrease) and extend the net balances to column 5. Column 5, line 200, must equal column 3,
line 200.

**Worksheet A General Line Descriptions:**

The trial balance of expenses is broken down into general service, inpatient routine service,
ancillary service, outpatient service, other reimbursable, special purpose, and non-reimbursable
cost center categories to facilitate the transfer of costs to the various worksheets.

**Lines 1 through 23**—These lines are for the general service cost centers. These costs are expenses
incurred in operating the facility as a whole that are not directly associated with furnishing patient care
such as mortgage, rent, plant operations, administrative salaries, utilities, telephone charges, computer
hardware and software costs. General service cost centers furnish services to both general service areas
and to other cost centers in the provider.

**Lines 24 through 29**—Reserved for future use.

**Lines 30 through 46**—These lines are for the inpatient routine service cost centers.

**Lines 50 through 76**—Use for ancillary service cost centers.

**Lines 77 through 87**—Reserved for future use.

**Lines 88 through 93**—Use these lines for outpatient service cost centers.

**Lines 94 through 100**—Use these lines for other reimbursable cost centers (other than HHA and
CMHC).

**Lines 102 through 104**—Reserved for future use.

**Lines 105 through 117**—Use these lines for special purpose cost centers. Special purpose cost
centers include kidney, heart, liver, lung, pancreas, intestinal, and islet acquisition costs as well as costs
of other organ acquisitions which are non-reimbursable but which CMS requires for data
purposes, cost centers which must be reclassified but which require initial identification, and ASC and
hospice costs which are needed for rate setting purposes.

**Lines 119 through 189**—Reserved for future use.

**Lines 190 through 194**—Record the costs applicable to non-reimbursable cost centers to which
general service costs apply.

1. **DATA SOURCES FOR BILL GRAPH DATA POINTS**

**Patient Care**—Patient Care expenses are pulled from worksheet A, column 5 for Inpatient and
Outpatient cost centers. Specifically, Inpatient routine cost centers reported on lines 30-46 and lines 88-
92.01 and ancillary cost centers, that include both inpatient and outpatient expenses, reported in lines 8
through 11, 13 through 17, 19 through 29 and 50 through 78.

**Capital**—Expenses used for capital are pulled from worksheet A, Column 5 lines 1-3.
The capital cost centers on lines 1 and 2 include depreciation, leases and rentals for the use of facilities and/or equipment, and interest incurred in acquiring land or depreciable assets used for patient care.

Line 3—In accordance with 42 CFR 412.302(b)(4), enter all other capital-related costs, including but not limited to taxes, insurance, and license and royalty fees on depreciable assets. This line also includes any directly allocated home office other capital cost.

Administrative Expenses—worksheet A, Column 5 line 5 and 18

Line 5—Enter A&G costs on this line. A&G includes a wide variety of provider administrative costs such as but not limited to cost of executive staff, legal and accounting services, facility administrative services. Additionally, other expenses reported in A&G include:

- Expenses related to IT/Electronic Health Record costs
- Medical Interpretation and Translation Services
- Appointment Center
- Risk Management
- Volunteer Services
- Finance
- Accounting
- Compliance
- Legal
- Pastoral Care & Education
- Billing
- Coding
- Admissions & Registration
- Purchasing

Maintenance Expenses – Worksheet A, Column 5 Lines 6 and 7

Line 6—Maintenance and repairs are any activity to maintain the facility and grounds such as, but not limited to, costs of routine painting, plumbing and electrical repairs, mowing and snow removal.

Line 7—Operation of plant includes the cost such as, but not limited to, the internal hospital environment including air conditioning (both heating and cooling systems and ventilation) and other mechanical systems.

Personnel Services – worksheet A, column 5 lines 4 and 12

Personnel services covers expenses that are considered compensation, but not salaries. The exception is human resource salaries, which are included in personnel expenses.
Line 4—Enter in column 1, the direct salaries and salary amounts for paid vacation, holiday, sick, other paid-time-off (PTO), severance, and bonus pay incurred only for employees in the employee benefits department and/or the human resources department. Enter in column 2 the employee benefits cost of employees in the employee benefits and/or human resources department.

Line 12—Maintenance of personnel includes the cost of room and board furnished to employees. (See CMS Pub. 15-1, chapter 7, §704.3.)

Other expenses – Worksheet Column 5 Lines greater than Lin 92.01 to 199 but not line 118

Total uncompensated care costs—worksheet S-10, Line 30
Cost of Uncompensated Care (Column 3 Line 23 (Cost of Charity Care) plus Column 1 Line 29 (Cost of non-Medicare and non-reimbursable Medicare bad debt expense))

2. PERCENTAGE OF HOSPITAL EXPENSES TOTAL

To calculate the percentage of each expense data point included in this graph, each expense total for each category is divided by the total expenses from worksheet A plus total uncompensated care costs. Each expense percentage for Patient Care, Admin, Capital, other, Personnel, Maintenance and Uncompensated Care is plotted on the Total Hospitals Expenses (%) in 2015 graph included on the individual hospital summary.

Payor Mix (Patient Days) in 2015
Worksheet S-3, Part I, Columns 6, 7 & 8, line 14 plus line 2

The Medicare cost report does not require reporting of charges by payor, therefore, for the individual hospital summary, total days will be used to calculate payor mix. NOTE: this payor mix methodology will not include outpatient services for this metric, however as charges by payor by hospital are not available on any publicly available data source, total days reported on worksheet S-3 of the cost report was the most suitable alternative option for a payor mix comparison.

Calculation:  Step 1: Add lines 14 and 2, then take Column 8 less columns Medicare (column 6) and Medicaid days (column 7) to calculate “all other” days.

Step 2: Medicare, Medicaid and All Other Days each divided by total days in Column 8 equals each payor mix percentage.

Hospital Type and Grouping
The hospital type listed on the individual report was determined based on Medicare licensing. For the state summary report, hospitals were grouped based on the Core-Based Statistical Area status of the hospital county. That is, if the county is contained in the Denver CBSA, then the hospital is considered a Denver Metro hospital; all other hospitals in urban CBSAs are considered “Other Urban.” Hospitals located in a county that does not have a CBSA designation are considered “Rural.” There are three critical access hospitals located in CBSA-designated urban counties; these three hospitals have been included in the rural peer group.

For the system summary reports, only hospitals were included that were part of the systems in 2015 and earlier. Hospitals who joined any systems after this year were not included in these summaries. Hospitals with incomplete fiscal year cost reports were still included; these values are marked with an asterisk.