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using the Medicare cost report to improve financial performance

The Medicare cost report can help you analyze costs and compare your organization against your competition.

AT A GLANCE

The Medicare cost report can help you understand your organization's financial performance by providing a means to:

- > Analyze costs
- > Assess departmental and payer margins
- > Compare performance with the competition

Making strategic decisions may require extensive resources, including time and financial commitments, for assessing a situation or planning a course of action. The process can involve mounds of reports, many hours of analysis, additional FTEs, and maybe even the expertise of a consultant. However, if you are looking for a quick tool for making strategic decisions, you may need to look only as far as your desktop or nearest file cabinet—wherever you house your Medicare cost report. Although the Medicare cost report has limitations, it may be one of your best first resources when evaluating financial issues at a high level.

Before you continue, grab your Medicare cost report so you can follow these examples and navigate through your cost report.

Understanding Cost

The Medicare cost report can help you analyze both routine and ancillary costs.

Routine cost analysis. Using your Medicare cost report and the worksheets noted in the top

exhibit on page 2, you can review direct cost per day, total cost per day, or total charge per day within routine service areas, such as adults and pediatrics, intensive care unit, and nursery. This review can provide insight into areas where staffing and pricing issues may need to be further evaluated.

For example, based on the exhibit, both Adults & Peds and Nursery warrant further attention as the total cost per day exceeds the total charge per day.

Ancillary cost analysis. In addition to evaluating routine costs, you can complete an ancillary cost analysis using the cost-to-charge ratios from Worksheet C, Part I. At a departmental level, this cost analysis can help you identify, on a fully allocated cost basis, departments whose costs exceed charges (a cost-to-charge ratio greater than 1.0). Although this analysis does not take into account payer mix and therefore does not consider allowances and discounts at the departmental level, it can still identify areas that may need further analysis.

A cost-to-charge ratio greater than 1.0 raises the question of whether the department should, or could, reduce costs to improve margin, or at a minimum, assist in making an informed decision

to continue operating the department as is. A cost-to-charge ratio significantly less than 1.0 provides information on an organization's charge structure and whether prices are still competitive or may have been driven up to an excessive level.

Note: Remember that professional charges are excluded from total charges on Worksheet C.

In addition to looking at your routine cost per day and cost-to-charge ratios annually, you can also compare these data for a historical period of time as shown in the top exhibit on page 3.

Through a historical comparison, you can observe changes that have occurred within your organization. It would be expected that over a period of time, cost-to-charge ratios likely would trend downward as price increases tend to exceed cost increases. As you trend your routine cost-per-day

Department managers sometimes find it difficult to manage indirect expenses because the managers may not be directly responsible for the allocation methodology or the expenses of the overhead department.

and cost-to-charge ratios, ask the following questions:

- > What percentage of changes has occurred in each of the years presented?
- > Are the results of the historical review as expected?
- > Are the changes supportable by operational activities?

ROUTINE COST ANALYSIS

Department	Worksheet B Part I Column 0 Direct Cost	Worksheet B Part I Column 27 Total Costs	Worksheet C Part I Column 8 Charges	Worksheet S-3 Part I Column 6 Days	Direct Cost/ Day	Total Cost/ Day	Total Charge/ Day
Adults & Peds	\$3,675,000	\$7,500,000	\$7,480,000	8,500	\$432	\$882	\$880
ICU	\$2,250,000	\$3,240,000	\$3,970,000	1,650	\$1,364	\$1,964	\$2,406
Nursery	\$350,000	\$550,000	\$245,000	950	\$368	\$579	\$258

This analysis shows that both Adults & Peds and Nursery warrant further attention as the total cost per day exceeds the total charge per day.

ANCILLARY COST ANALYSIS, 2010

Department	Worksheet C Part 1 Column 5 Total Costs	Worksheet C Part 1 Column 8 Total Charges	Worksheet C Part 1 Column 9 Total Cost-to- Charge Ratio
Operating room	\$2,252,000	\$6,000,000	0.375333
Radiology - Diagnostic	\$3,883,000	\$14,200,000	0.273451
Physical therapy	\$1,925,000	\$1,800,000	1.069444
Drugs charged to patients	\$1,813,000	\$3,300,000	0.549394
Emergency	\$2,600,000	\$2,000,000	1.300000

This cost analysis can help you identify, on a fully allocated cost basis, departments whose costs exceed charges.

HISTORICAL ANALYSIS

Department	2008	2009	2010
Adults & Peds routine cost per day	\$1,082	\$1,043	\$882
Operating room cost-to-charge ratio	0.495451	0.895319	0.375333
Radiology-diagnostic cost-to-charge ratio	0.359620	0.294168	0.273451
Physical therapy cost-to-charge ratio	1.154750	1.192100	1.069444

You can also compare routine cost per day and cost-to-charge ratios for a period of time.

- > What opportunities may exist to adjust cost-to-charge ratios that are significantly less than or greater than 1.0?

Profitability by Department

To help you understand what costs are driving a departmental cost-to-charge ratio up to or over 1.0, Worksheet B, Part I provides the detail of the cost components. Overhead departmental cost is allocated to revenue-producing departments, using statistics reported in the cost report, resulting in fully allocated costs.

Fully allocated cost at a departmental level can provide insight into profitability, especially for service lines that are not core hospital ancillary departments such as a skilled nursing facility (SNF), home health agency, clinic, hospice, or nonreimbursable cost center such as a Meals on Wheels program.

Fully allocated costs include all departmental direct expenses and a portion of indirect expenses. Department managers sometimes find it difficult to manage indirect expenses because

the managers may not be directly responsible for the allocation methodology or the expenses of the overhead department. To alleviate focus on expenses that are managed by another department and out of your control, you can measure a department's financial performance based on a direct cost-to-charge ratio. The direct cost-to-charge ratio analysis is helpful for trending as well as understanding controllable costs.

For example, the exhibit below reflects the direct cost-to-charge ratio for an operating room of 0.166667. This amount represents the controllable costs for this department compared with the total cost-to-charge ratio of 0.375333 reflected in the exhibit above.

The above analysis reflects the relationship of controllable costs to charges. If allowances and discounts are taken into account, the net result is the contribution margin.

Contribution margin is revenue less allowances and discounts remaining after "direct" expenses have been subtracted. The remaining amount, or

DEPARTMENT PROFITABILITY

Cost Center Department	Worksheet B Part 1, Column 0 Direct Cost	Worksheet C Column 8 Total Charges	Direct Cost-to- Charge Ratio
Operating room	\$1,000,000	\$6,000,000	0.166667
Radiology-diagnostic	\$2,200,000	\$14,200,000	0.154930
Physical therapy	\$1,000,000	\$1,800,000	0.555556

This analysis reflects the relationship of controllable costs to charges.

STATEMENT OF OPERATIONS		
Medicare Cost Report Reference	Description	Amount
Revenue:		
Wkst C, Part I, Col 8, Line 34	Skilled nursing facility (SNF) revenue	\$1,930,000
From Internal Records	Less - Contractual adjustments	(440,000)
Subtotal	Net SNF revenue	<u>1,490,000</u>
Expenses:		
Wkst A, Col 1, Line 34	Direct salary expense	750,000
Wkst A, Col 2, Line 34	Direct other expense	150,000
Wkst B, Part I, Col 5, Line 34	Employee benefits	195,000
Subtotal	Total direct expenses	<u>1,095,000</u>
Wkst B, Part I, Cols 3-4 & 6-24, Line 34	Contribution margin*	395,000
	Indirect expenses	675,000
	Expenses in excess of revenue	<u><u>\$(280,000)</u></u>
	*Contribution margin percentage	<u><u>26.5%</u></u>

Using the Medicare cost report, you can identify the direct cost, contribution margin, and fully allocated cost of a skilled nursing facility operation.

contribution margin, is the amount available to cover fixed and overhead expenses. If a department has a small contribution margin or possibly a negative contribution margin, this knowledge can prove valuable for decision making and strategic development. For example, if you are looking to add FTEs to a department, you might first want to see if current revenue less allowances and discounts is covering direct expenses.

Although reviewing direct expenses is a good first step when analyzing a department or service line, to fully understand the operational effectiveness, you should review the financial performance on a fully allocated cost basis. To begin, you can use the Medicare cost report to build a statement of operations for the department or service line under analysis.

For example, consider the financial performance for a SNF that is operated by a health system. As budgets continue to be tightened at a state level, these facilities are coming under closer scrutiny for many health systems.

For most SNFs, providing Medicare services is profitable, and operational strategies often focus on attracting residents who have Medicare coverage. Medicaid services, on the other hand, present a financial struggle for SNFs. According to *A Report on Shortfalls in Medicaid Funding for Nursing Home Care* prepared for the American Health Care Association, the total amount of unreimbursed care per Medicaid patient day for 2009 was projected at \$14.17, on average, nationwide. Only the District of Columbia, Michigan, and Oregon reported Medicaid reimbursement that covered costs. For the remaining states, unreimbursed costs per Medicaid day ranged from \$0.79 in Idaho to \$28.41 in Wisconsin. Using the Medicare cost report, you can identify the direct cost, contribution margin, and fully allocated cost of a SNF operation as shown in the exhibit above.

Although it is important to stress again that using the Medicare cost report for this type of analysis is at a high level, it is evident that SNFs have financial challenges. Despite the financial challenges, however, SNFs can contribute importantly to the mission of healthcare organizations.

With the aging population and the impact of healthcare reform, organizations need to make good strategic decisions related to the skilled nursing facility rather than hasty decisions based strictly on top-level financial information.

With the aging population and the impact of healthcare reform, organizations need to make good strategic decisions related to this department rather than hasty decisions based strictly on top-level financial information. If the financial performance is not at an acceptable level, such as the \$280,000 loss noted in the Statement of Operations on page 4, additional analysis should be completed before any type of action is taken, such as closing, selling, or otherwise spinning off the SNF.

Additional analysis is warranted not only because of the revenue generated by SNF residents for ancillary services, but also because of the potential inpatient revenue the residents could generate. SNF residents generate revenue through ancillary services provided at the hospital, such as radiology, therapy, and laboratory. Because the Medicare cost report captures the ancillary revenue and related expenses in each department (e.g., radiology department), the SNF is not receiving credit for any "financial benefit" from the hospital revenue generated for its residents. In addition to the revenue generated from the SNF residents for outpatient ancillary services, the SNF generally is a "feeder" for inpatient services for the hospital. This inpatient business could go elsewhere if the SNF were to cease operations.

Although the SNF may never generate a margin under a fully allocated cost methodology, a

departmental cost analysis may help shed light on future considerations. The following are key questions for such an analysis:

- › Based on current occupancy and the future market needs, is the SNF the "right size"?
- › Is the facility doing a good job of remaining competitive and attracting the best payers (Medicare and private pay)?
- › At a contribution margin of 26.5 percent, does the department have an opportunity to make operational changes, such as adjusting staffing levels, to increase the contribution margin?
- › Are private pay rates set at the proper level?
- › If the hospital is certified as a critical access hospital for payment purposes and a change is made to the SNF operation, can indirect costs be reallocated to improve hospital payment?
- › Can laundry or meals be outsourced for a reduced rate?

Outsourcing Services

Outsourcing services is another area for analysis. Does your health system provide services to others, such as meals, rental space, or laundry?

When was the last time you analyzed the cost of these services for either rate setting or continuation of providing the service? The Medicare cost report can provide a tool for this type of analysis. The unit cost multiplier on Worksheet B-1, Line 104 is the fully allocated cost per unit (statistics used for each department, such as square feet) for general service cost centers at a high level. The unit cost multiplier can be used as a starting point to set the rate for a certain service and can also be used as a tool to determine whether the service

OUTSOURCING SERVICES

Cost Center Description	Unit Cost Multiplier
Building depreciation	\$16.60
Operation of plant	\$12.30
Housekeeping	\$11.50
Cafeteria	\$6.70

You can analyze the cost of services your organization provides to others for either rate setting or continuation of providing the service.

PROFITABILITY BY PAYER

Medicare Inpatient:	Description	Amount
Wkst D-1, Part II, Line 49	Total program inpatient costs	\$4,167,000
Wkst E, Part A, Line 17	Primary payer payments	\$10,000
Wkst E, Part A, Lines 19 - 20	Deductibles and coinsurance	\$410,000*
Wkst E, Part A, Line 28	Interim payments	\$3,390,000
	Total payments	\$3,810,000
	Cost in excess of payments-Inpatient	(\$357,000)
Medicare Outpatient:		
Wkst E, Part B, Lines 1 - 1.01	Total outpatient costs	\$2,548,000
Wkst E, Part B, Lines 18 - 18.01	Deductible and coinsurance	\$555,000*
Wkst E, Part B, Line 24	Primary payer payments	\$5,000
Wkst E, Part B, Line 34	Interim payments	\$1,500,000
	Total payments	\$2,060,000
	Cost in excess of payments-Outpatient	(\$488,000)
	Total Medicare costs in excess of payments	(\$845,000)

*Assuming full payment on deductibles and coinsurance.

This analysis compares payments with the fully allocated cost for inpatient and outpatient services.

can be purchased at less cost than currently provided.

You can begin to determine a rate per square foot by identifying the unit cost multiplier for building depreciation. As shown in the exhibit on page 5, the depreciation component is \$16.60 per square foot. This amount is the base for determining the rate. Depending on the terms of the contract, the base amount of \$16.60 may need to be increased for utilities, maintenance, and even housekeeping. Because the unit cost multiplier for operation of plant and housekeeping is increased through the step-down process for other overhead costs, such as administration and even depreciation expense, the analysis unfortunately is not as simple as adding all the various unit cost multipliers to determine the rate. Nevertheless, it is a starting point for an analysis.

The unit cost multiplier for cafeteria is another example of how an initial rate per meal may be evaluated. Based on the above, the unit cost multiplier indicates that the cost per meal is \$6.70.

If this service was provided by a healthcare system through a third party, the data would be valuable for setting the contract rate for this service.

Margin by Payer

In addition to reviewing margin by department, the Medicare cost report can provide insight into margin by payer, primarily Medicare. A hospital paid using a prospective payment methodology can use the Medicare cost report to compare payments with the fully allocated cost for inpatient and outpatient services.

The analysis above discloses that the hospital is experiencing a shortfall in payments from the Medicare program of \$845,000. Although this type of analysis is helpful when managing operations, it also provides valuable data for disclosure on Schedule H of the Form 990, Tax-Exempt Return for Organization Exempt from Income. A similar analysis can also be completed using Worksheet E-3, Part III for Medicaid (if the cost report schedules are completed).

BENCHMARKING YOUR COMPETITION

Benchmark	Formula
Adults & Peds occupancy percentage (and others)	Worksheet S-3, Part I, Column 6, Line 1 / Column 1, Line 1 (Beds) * 365
ALOS—Adults & Peds	Worksheet S-3, Part I, Column 6, Line 1 / Column 15, Line 1
Medicare utilization:	
Routine	Worksheet S-3, Part I, Column 4, Line 1 / Column 6, Line 1
Ancillary	Worksheet D, Part V, Column 5 plus D-4 for Department Line / Worksheet C, Part I, Column 8 for Department Line
Overhead expenses as a percentage of total expenses	Worksheet B, Part I, Column 0, Lines 3-24 / Column 0, Line 103
Outpatient charges as a percentage of total charges	Worksheet C, Part I, Column 7, Line 103 / Column 8, Line 103
Cost per diem for hospital routine	Worksheet D-1, Part II (Hospital), Line 38
Cost per diem for SNF	Worksheet D-1, Part III, (SNF), Line 67

You can develop benchmarks to compare your organization with your competitors.

Benchmarking Your Competition

If preparing or reviewing the Medicare cost report is not part of your job description, you may not realize the wealth of financial information the report contains about your organization.

Although you may have many other tools within your organization to gather the same or similar data that can be obtained from the Medicare cost report, one advantage of using the Medicare cost report is that you can also obtain information about your competitors. Through the Freedom of Information Act, you can request cost reports for any provider by contacting your fiscal intermediary or the Centers for Medicare & Medicaid Services. There are also vendors from whom you can purchase this type of data.

After spending time comparing, analyzing, and dissecting your cost report data, consider developing a summary of benchmarks comparing your organization with your competitors. You can use the exhibit above to develop such a comparison.

Your Medicare Cost Report Tool

The Medicare cost report is a tool you can use to gain a better understanding of the financial performance of your organization and your

neighboring competition. Hopefully, you need look only as far as your desktop or nearest file cabinet to find your Medicare cost report and begin this high-level analysis. ●

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