Provision of Uncompensated Care by Rural Hospitals: A Preliminary Look at Medicare Cost Report Worksheet S-10

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Abstract

Purpose: To conduct a preliminary assessment of the quality of uncompensated care data included in Medicare Cost Report (MCR) Worksheet S-10 for rural hospitals and to identify the implications of data quality issues for research and policy decisions.

Methods: 2011 MCR Worksheet S-10 data for all rural hospitals were collected from the Healthcare Cost Reporting Information System (HCRIS). Rural hospitals were partitioned into two sub-groups: CAHs and all other rural hospitals (ORHs.) Two tests of data quality were undertaken. First, for each study variable, we counted the number of hospital cost reports where the value was positive, zero, or negative. Second, we calculated the percentile values of study variables that were positive.

Findings: Several data quality issues in Worksheet S-10 were identified: 1) large numbers of zero values, particularly among Medicaid and SCHIP programs; 2) possible incomplete capture of the total initial obligation of patients approved for charity care, and; 3) zero and negative values for charity care, bad debt, total uncompensated cost and the grand total.

Conclusions: There are several implications of the study. First, use of these data for policy making and research at this point in time could be imprecise. Second, consistency with other data sources could improve the quality of data in Worksheet S-10. Third, revisions to Worksheet S-10 may be needed.

Key words Worksheet S-10, critical access hospitals, rural hospitals, Medicare, rural.

INTRODUCTION

Hospitals report that they provide a lot of care for which they receive no reimbursement. In a recent survey of 4,973 hospitals by the American Hospital Association, charity care and bad debt together in 2011 totaled $41.1 billion and accounted for 5.9 percent of total expenses[1]. This may result from reimbursement rates that are below the cost of providing care to patients covered by certain government programs such as Medicaid, SCHIP and state or local indigent care programs. Alternatively, the care may be truly uncompensated (i.e., charity and/or bad debt). Charity care is provided to patients who have demonstrated an inability to pay for services; this differs from bad debt which results from providing care to a patient who is able but unwilling to pay for services or who is unwilling to provide documentation supporting their inability to pay for services.

Health care administrators and policy makers need consistent reporting and clear distinction between the different sources of uncompensated cost. The Principles and Practices Board of the Healthcare Financial Management Association has identified five reasons why it is important to clearly and accurately distinguish between charity care and bad debt:

1. “Charity care represents the consumption of valuable uncompensated resources that must be managed wisely.
2. Charity care is an important indicator of the fulfillment of an organization's charitable purposes and, therefore, should be clearly identified and disclosed.
3. Rigorous separating of charity care from bad debt is critical to the disclosure of charity care and community benefit reports.

4. Bad debt expense is one key measure of the organization's revenue cycle effectiveness. This is particularly important because additional credit risk is being placed on providers as patient copayments increase.
5. Distinguishing between charity and bad debt is important for compliance purposes and for extending discounts based on a demonstrable financial need"[5]

For rural hospitals, distinguishing between unreimbursed costs, charity care and bad debt is particularly important because they receive a relatively greater proportion of total revenue from government payers. Electronic Health Record (EHR), Disproportionate Share (DSH), and Medicare bad debt reimbursements are all affected by the amounts reported for charity care and bad debt.

Despite the importance of uncompensated care information, reporting practices have been inconsistent and have contributed to confusion about the amount of charity care *actually* provided by hospitals and the amount of bad debt *actually* incurred by hospitals.[9] Responding to pressure from politicians such as Senator Chuck Grassley[2] and calls from professional bodies such as the Financial Accounting Standards Board and Healthcare Financial Management Association for more transparent and consistent reporting, the Centers for Medicare and Medicaid Services expanded collection of uncompensated care information in Worksheet S-10 of the newly revised (2010) Medicare Cost Report (CMS 2552.)

The purpose of this study is to conduct a preliminary assessment of the quality of uncompensated care data included in the new Worksheet S-10 for rural hospitals and to identify the implications of data quality issues for research and policy decisions.

THE NEW MEDICARE COST REPORT

The Centers for Medicare and Medicaid Services (CMS) requires that hospitals that participate in the Medicare program submit a Medicare Cost Report annually. The cost report contains information such as provider facility information, utilization data, costs and charges, Medicare settlement data, and financial statement data. Because cost report data are publicly available, there is widespread use of this information for research and policy decisions.

In 2010, CMS released an updated version of the Medicare Cost Report, now titled Form 2552-10. This is the first major revision to the cost report since 1996. While hundreds of changes were made throughout the cost report, Worksheet S-10, Hospital Uncompensated and Indigent Care Data, saw the most dramatic overhaul. Worksheet S-10 is used to collect charges and payments for uncompensated and indigent care and to calculate the associated cost for that care. [3] The updated S-10 delves into significantly more detail regarding the cost of providing uncompensated care than the previous 1996 version.

Table 1 lists the Worksheet S-10 component accounts used to estimate total unreimbursed and uncompensated care cost. Total uncompensated care is divided into two primary sections: (1) unreimbursed cost from Medicaid, SCHIP and state or local indigent care programs, and (2) uncompensated cost including charity care and bad debt. The data quality of the study variables listed in the first column of Table 1 is the subject of this study.

UNREIMBURSED COST

MCR Worksheet S-10 differentiates between unreimbursed costs of providing care to patients covered under government programs and uncompensated care. Unreimbursed cost includes Medicaid, stand-alone State Children's Health Insurance Programs (SCHIP) and state or local

indigent care programs. The unreimbursed cost for a Medicaid, SCHIP, or state or local indigent care program is estimated as the difference between the program's net revenue (for example, Medicaid DSH) and the costs of the program (Table 1). For each program, cost is estimated by the product of total charges for patients covered under the program and the hospital's cost to charge ratio.

UNCOMPENSATED COST

Uncompensated cost includes the cost of providing care to patients that qualify for charity care, and the cost of services that are unreimbursed because patients fail to pay (bad debt). The determination of each in Worksheet S-10 is discussed below.

Charity Care

According to the Centers for Medicare and Medicaid Services Provider Reimbursement Manual, charity care is defined as "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. For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt."[4]

Table 1 shows that the uncompensated cost of charity care is estimated as the product of the total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) and the cost to charge ratio for the hospital. Partial payments by patients approved for charity care are then subtracted to determine the final unreimbursed cost of charity care.

Bad Debt

The Worksheet S-10 instructions state that bad debt includes both Non-Medicare bad debt and Non-reimbursable Medicare bad debt. Non-Medicare bad debt is defined as "health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim."[7] Non-reimbursable Medicare bad debt is "the amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1."[7]

Table 1 shows that Medicare bad debt expense is subtracted from total bad debt expense for the hospital and this value is multiplied by the cost-to-charge ratio for the hospital.

METHODS

There are currently 4 classifications of rural hospitals that can qualify for special payment provisions under Medicare: Critical Access Hospitals (CAHs), Medicare Dependent Hospitals (MDHs), Sole Community Hospitals (SCHs), and Rural Referral Centers (RRCs). These hospitals are exempt from the Inpatient Prospective Payment System (IPPS) that Medicare uses to pay for services provided by most acute care hospitals. Eligibility for the CAH, MDH, and SCH designations is based on several factors, including size and location, and most are small, rural facilities.

The majority of rural hospitals are CAHs and they are different from other types of rural hospitals. CAHs are reimbursed for 101% of their Medicare allowable costs for inpatient and outpatient care. Reimbursement to other rural hospitals with special Medicare payment provisions is based on either an adjusted PPS payment or a hospital-specific rate calculated from

historical costs. CAHs have no more than 25 beds, a maximum average length of stay of 4 days, and a minimum distance to another facility, whereas other rural hospitals don't face these specific requirements.

These differences between CAHs and other rural hospitals prompted a decision to partition rural hospitals into two sub-groups for this analysis: CAHs and all other rural hospitals (ORHs), which includes MDHs, SCHs, and RRCs.) It was considered that interpretation of Worksheet S-10 data for the large group of CAHs would be more meaningful without the effects of larger rural hospitals. Worksheet S-10 data for 2011 for 1,139 CAHs and 780 ORHs were drawn from Medicare Cost Reports in the Healthcare Cost Reporting Information System produced by the Center for Medicare and Medicaid Services.

For each study variable, two tests of data quality were undertaken. First, the number of hospital cost reports where the value was positive, zero, or negative was counted. Second, for hospital cost reports where the value was positive, the percentile values were calculated. Hospital cost reports with zero or negative values were excluded because percentiles of a distribution where the majority of observations are zero are not particularly revealing.

RESULTS

Table 2 shows the results of the two data quality tests for CAH hospital cost reports and Table 3 shows the results for ORHs.

Medicaid

In Worksheet S-10, data on lines 2 through 7 are used to estimate the unreimbursed cost of services paid by *Medicaid* (line 8.) Table 2 shows that 360 CAHs reported *Medicaid* values of

zero and Table 3 shows that 287 ORHs reported zero values. The primary reason for the large number of zero values was that 308 CAHs and 253 ORHs reported *Medicaid* costs less than net revenue and, in this circumstance, hospitals are instructed to enter zero. Fifty-two (52) CAHs and 34 ORHs reported values of zero for both Medicaid costs and net revenue. This may occur because many states use cost-based reimbursement to pay CAHs for Medicaid patients. A hospital's initial payment rates are based on the last Medicaid cost report filed. Any fluctuation between the interim rates set and paid throughout the year, and the actual costs for the year, is reflected in the end-of-year cost report settlement. If Medicaid paid too much, the CAH must repay some money to the program. If Medicaid estimated payments are less than what the Medicaid cost report says they should have been, the hospital will receive additional payment from Medicaid. Therefore, if a hospital's interim Medicaid rates are above the Medicaid cost calculated on line 7 of Worksheet S-10, two potential problems are created: (1) there will be a Medicaid repayment that will happen after Worksheet S-10 has been submitted, and/or (2) the costs calculated on Worksheet S-10 are less than those calculated on the Medicaid Cost Report. These problems are more of a timing problem in the cost report calculations on Worksheet S-10 than a problem in the quality of data compiled by the providers.

Among hospital cost reports with a positive value in line 8, the median unreimbursed cost of *Medicaid* services for CAHs was $358,167 and $1,471,441 for ORHs.

SCHIP

In Worksheet S-10, data on lines 9 through 11 are used to estimate the unreimbursed cost of services reimbursed by *SCHIP* (line 12.) Table 2 shows that 1004 CAHs reported *SCHIP* values of zero and Table 3 shows that 651 ORHs reported zero values. One reason for the large number

of zero values is that reporting is for stand-alone SCHIP programs. According to CMS's Worksheet S-10 Instructions, these programs "cover recipients who are not eligible for coverage under Title XIX" and this should "include payments for all services except physician or other professional services, and include any payments received from SCHIP managed care programs."[7] As of 2010, seven states structured their SCHIP as part of Medicaid, 28 had combination programs, and 15 had separate child health programs.[5]

It was expected that this classification would determine how the worksheet was completed (i.e. whether SCHIP amounts were included in Medicaid or separated), but there was no visible association between program type and whether values were zero. Three of the 15 separate program states did not have any hospitals with reported SCHIP values. Twenty of the 28 states with combination programs had at least one hospital with values for the SCHIP summary line.

Among hospital cost reports with a positive value in line 12, the median unreimbursed cost of *SCHIP* services for CAHs was $14,403 and $30,321 for ORHs.

Indigent care

In Worksheet S-10, data on lines 13 through15 are used to estimate the unreimbursed cost of *indigent care* programs (line 16.) Table 2 shows that 980 CAHs reported *indigent care* values of zero and Table 3 shows that 631 ORHs reported zero values. This may occur because many hospitals do not have a separate indigent care program that is funded separately from Medicaid, SCHIP or charity care. Among hospital cost reports with a positive value in line 16, the median unreimbursed cost of *indigent care* for CAHs was $86,872 and $289,450 for ORHs.

Total Unreimbursed Cost

In Worksheet S-10, *Medicaid* (line 8), *SCHIP* (line 12), and *indigent care* (line 16) are summed to estimate the *total unreimbursed cost* (line 19.) Table 2 shows that 284 CAHs reported *total unreimbursed cost* values of zero and Table 3 shows that 208 ORHs reported zero values. Among hospital cost reports with a positive value in line 19, the median *total unreimbursed cost* for CAHs was $340,886 and $1,233,498 for ORHs.

Charity Care

In Worksheet S-10, data on lines 20-23 (Column 3) are used to estimate the uncompensated cost of *charity care* (line 23.) Lines 20-23 include three columns: uninsured patients, insured patients, and total. According to CMS Worksheet S-10 instructions, the uninsured patients column includes "patients with coverage from an entity that does not have a contractual relationship with the provider."[7] The insured patients column includes "patients covered by a public program or private insurer with which the provider has a contractual relationship."[7] Column 3 is simply the total of columns 1 and 2.

Table 2 shows that 129 CAHs reported *charity care* values of zero and Table 3 shows that 69 ORHs reported zero values. More worrisome, 12 CAHs and 16 ORHs reported negative values. This occurs when the *Partial payment* (line 22) value is greater than the *Cost of initial obligation* (line 21). The hospital cost to charge ratio is derived from Worksheet C, so the reason for negative values could be incomplete capture of the total initial obligation of patients approved for charity care (at full charges).

Among hospital cost reports with positive values in line 23, the median charity care cost for CAHs was $180,756 and $821,060 for ORHs.

Bad Debt

In Worksheet S-10, data on lines 26-27 are used to estimate the uncompensated cost of *bad debt* (line 29.) Table 2 shows that 25 CAHs reported *bad debt* values of zero and Table 3 shows that 17 ORHs reported zero values. More worrisome, 128 CAHs and 161 ORHs reported negative values.

The primary reason for the large number of negative values was that 175 CAHs and 142 ORHs did not report a value for line 26 which captures total bad debt expense for the entire hospital complex. Line 28 (Non-Medicare and non-reimbursable bad debt expense) is calculated by subtracting line 27 (Medicare bad debts) from line 26. When line 26 was missing, line 28 was calculated to be negative. Among hospital cost reports with values for line 26, some included Medicare bad debts that were larger than Total bad debt expense, also creating negative values for line 28.

Among hospital cost reports with positive values in line 29, the median *bad debt* cost for CAHs was $550,886 and $1,677,413 for ORHs.

Total Uncompensated Cost

In Worksheet S-10, *charity care* (line 23) and *bad debt* (line 29) are summed to estimate the *total uncompensated cost* (line 30). Table 2 shows that 9 CAHs reported *total uncompensated cost* values of zero and Table 3 shows that 10 ORHs reported zero values. More worrisome, 76 CAHs and 38 ORHs reported negative values. Among hospital cost reports with positive values in line 30, the median *total uncompensated cost* for CAHs was $769,653 and $2,296,972 for ORHs.

Total Unreimbursed and Uncompensated Cost

In Worksheet S-10, *total unreimbursed cost* (line 19) and *total uncompensated cost* (line 30) are summed to estimate the grand total (line 31.) Table 2 shows that 6 CAHs reported *total unreimbursed and uncompensated cost* values of zero and Table 3 shows that 7 ORHs reported zero values. More worrisome, 57 CAHs and 25 ORHs reported negative values. Among hospital cost reports with positive values in line 31, the median grand total unreimbursed and uncompensated cost for CAHs was $1,098,965 and $3,525,647 for ORHs.

CONCLUSIONS AND RECOMMENDATIONS

This study identified several data quality issues in Worksheet S-10:

1) Large numbers of zero values, particularly among unreimbursed cost from Medicaid and SCHIP programs. It is surprising that 284 of 1139 (25 percent) of CAHs and 208 of 780 (27 percent) of ORHs reported no *total unreimbursed cost* in line 19. Among these hospitals, either the costs were less than the net revenue or there were no costs or net revenue reported.
2) Possible incomplete capture of the total initial obligation of patients approved for charity care (at full charges).
3) Negative values for *bad debt*, caused by zero values for total bad debt expense for the entire hospital complex or Medicare bad debts larger than total bad debt expense.
4) Zero and negative values for *total uncompensated cost* and *grand total* of total unreimbursed and total uncompensated cost.

In practice, some of these data quality issues may be due to the fact that it is often difficult for hospitals to distinguish between charity care and bad debt because services are often

provided without consideration of a patient's ability to pay. The urgency and unpredictability of some treatments, complex billing arrangements, and processing and payment delays by government and third party payers are pervasive. In addition, determining a patient's ability to pay and the amount of service eligible for charity support is complex and requires judgment.[6]

There are several implications of these findings. First, *use of these data for policy making and research at this point in time could be imprecise*. For example, beginning October 1, 2013, Medicare DSH payments will be reduced by 75%. The remaining funds will be used to create an uncompensated care pool "distributed to DSH hospitals based on the ratio of the total amount of uncompensated care provided by the hospital to the total amount of uncompensated care provided by all DSH hospitals."[7] Although CMS has not released a data source for this calculation of uncompensated care, many believe Worksheet S-10 will be used. In addition, the amount of charity care charges is one of the factors used to calculate a hospital's Electronic Health Record (EHR) payment under the Medicare and Medicaid EHR Incentive Program. These payments are intended to help rural hospitals "adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology." [8] Incomplete charge capture for patients qualifying for charity care may reduce EHR payments since the final EHR payment rule states that line 20 of Worksheet S-10 will be used for the payment calculation. Moreover, if this value is determined to be inaccurate, all charge data will be excluded from the calculation. It is also likely that states will use this same data source to calculate the Medicaid EHR incentive payment.[9]

Second, *consistency with instructions and data collection in other data sources could improve the quality of data in Worksheet S-10.* Schedule H of the IRS 990 is required by all tax-exempt hospitals and contains information on charity care provided during the tax

year. The organization and methods of Schedule H have the potential to conflict with values reported on Worksheet S-10. Specifically, Section B. Item 8 of Schedule H allows multiple means of calculating the cost of charity care, one of which is using the cost-to-charge ratio, as is used in Worksheet S-10; however, the cost factor from the hospital cost accounting system or other approach may be used. Differences in results from IRS 990-H and Worksheet S-10 could cause problems for audits or calculation of payments in the future.

Third, and perhaps most important, *revisions to Worksheet S-10 may be needed*. More precise instructions and consistency between the form and the instructions may reduce data quality problems. For example, in the versions that were used for this study, the form and instructions for Medicaid, SCHIP and indigent care differed. For Medicaid, line 8 on the form stated "line 2 plus line 7 minus line 5" which is net revenue minus cost. Conversely, the instructions for line 8 stated "subtracting the sum of lines 2 and 5 from line 7" which is cost minus net revenue. Such discrepancies may seem trivial but they may account for some of the data quality issues identified in this study. Another example is Non-Medicare bad debt which is defined in the cost report instructions as "health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim." In practice, however, it is more accurate to state that bad debt is "health services for which a hospital has not determined the non-Medicare patient lacks the financial capacity to pay, but the non-Medicare patient is unwilling to settle the claim." This is an important distinction because there is a portion of bad debt that would meet the criteria of charity care if a patient were to submit the requested documentation.

Worksheet S-10 is an important step toward consistent reporting and clear distinction between the different sources of uncompensated cost. Resolution of the data quality issues identified in this study will be required for health care managers and policy makers to make effective use of these data.

Table 1. Study Variables

	Worksheet S-10		
Study Variable	**Line**	**Calculation**	**Description**
	1		Cost to charge ratio (Worksheet C, Part I line 200 column 3 divided by line 200 column 8)
	2		Net revenue from Medicaid
	5		If line 4 is no, enter DSH or supplemental payments from Medicaid
	6		Medicaid charges
	7	1 X 6	Medicaid cost
Medicaid	8	2 + 5 - 7	Difference between net revenue and costs for Medicaid program
	9		Net revenue from stand-alone SCHIP
	10		Stand-alone SCHIP charges
	11	1 X 10	Stand-alone SCHIP cost
SCHIP	12	9 - 11	Difference between net revenue and costsfor stand-alone SCHIP
	13		Net revenue from state or local indigent care program (not included on lines 2, 5 or 9)
	14		Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)
	15	1 X 14	State or local indigent care program cost
Indigent care	16	13 - 15	Difference between net revenue and costs for state or local indigent care program
Total unreim	19	8 + 12 + 16	Total unreimbursed cost for Medicaid, SCHIP, and state and local indigent care programs
	20		Total initial obligation of patients approved for charity care (at full charges excluding 20 non-reimbursable cost centers) for the entire facility
	21	1 X 20	Cost of initial obligation of patients approved for charity care
	22		Partial payment by patients approved for charity care
Charity care	23	21 - 22	Cost of charity care
	26		Total bad debt expense for the entire hospital complex (see instructions)
	27		Medicare bad debts for the entire hospital complex (see instructions)
	28	26-27	Non-Medicare and non-reimbursable bad debt expense
Bad debt	29	1 X 28	Cost of non-Medicare bad debt expense
Total uncomp	30	23 + 29	Cost of non-Medicare uncompensated care
Grand total	31	19 + 30	Total unreimbursed and uncompensated care cost

Table 2. Unreimbursed and Uncompensated Cost Reported by Critical Access Hospitals for 2011

	Unreimbursed cost				Uncompensated cost			
	Medicaid	SCHIP	care	unreim*	Charity Care	Bad debt	uncomp*	Grand total*
Number of hospital cost reports with study variable that is:								
Positive	779	135	149	855	998	986	1054	1076
Zero	360	1004	980	284	129	25	9	6
Negative	0	0	0	0	12	128	76	57
	1139	1139	1129	1139	1139	1139	1139	1139
For hospital cost reports with study variable that is positive:								
100%	$11,889,725	$964,214	$3,419,836	$11,889,725	$25,972,655	$5,327,564	$26,746,915	$26,746,915
99%	$4,341,799	$822,176	$2,335,899	$4,298,620	$3,341,850	$3,217,093	$5,093,719	$7,504,516
95%	$2,504,138	$187,509	$1,503,582	$2,663,823	$1,544,841	$2,136,188	$3,065,390	$4,857,540
90%	$1,732,692	$107,578	$1,057,734	$1,765,859	$995,356	$1,641,888	$2,380,141	$3,737,591
75% Q3	$922,190	$52,594	$361,600	$923,710	$495,186	$977,897	$1,398,440	$2,171,808
50% Median	$358,167	$14,403	$86,872	$340,886	$180,756	$550,886	$769,653	$1,098,965
25% Q1	$147,777	$3,307	$16,371	$125,251	$57,666	$274,880	$345,371	$493,743
10%	$49,440	$1,106	$1,925	$31,104	$18,911	$115,626	$132,188	$223,801
5%	$26,584	$391	$1,055	$13,158	$9,015	$63,159	$65,021	$118,881
1%	$6,625	$94	$208	$923	$1,066	$12,830	$19,404	$34,135
0% Minimum	$923	$20	$16	$16	$61	$97	$644	$4,772

* Dollar values are percentiles and may not equal the sum of the component parts.

Table 3. Unreimbursed and Uncompensated Cost Reported by Other Rural Hospitals for 2011

	Unreimbursed cost				Uncompensated cost			
Data quality test	Medicaid	SCHIP	Indigent care	Total unreim*	Charity Care	Bad debt	Total uncomp*	Grand total*
Number of hospital cost reports with study variable that								
Positive	493	129	149	572	695	602	732	748
Zero	287	651	631	208	69	17	10	7
Negative	0	0	0	0	16	161	38	25
Total	780	780	780	780	780	780	780	780
For hospital cost reports with study variable that is								
100% Maximum	$43,730,599	$3,026,254	$16,234,234	$43,730,599	$157,207,318	$15,357,647	$159,407,116	$159,407,116
99%	$24,296,248	$1,818,770	$6,654,491	$16,348,170	$12,083,243	$9,491,320	$16,838,902	$29,918,468
95%	$7,630,681	$307,791	$3,875,317	$7,929,240	$5,222,630	$6,006,312	$9,789,727	$14,084,841
90%	$5,511,135	$171,310	$2,608,411	$5,490,791	$3,463,504	$4,469,980	$6,751,467	$10,690,196
75% Q3	$3,080,620	$64,971	$1,222,872	$2,829,985	$1,989,343	$2,704,609	$4,234,269	$6,337,628
50% Median	$1,471,441	$30,321	$289,450	$1,233,498	$821,060	$1,677,413	$2,296,972	$3,525,647
25% Q1	$605,124	$10,659	$34,731	$481,832	$270,143	$919,173	$1,133,069	$1,683,227
10%	$254,999	$2,980	$4,958	$105,828	$71,457	$511,260	$341,038	$618,426
5%	$114,947	$1,706	$1,384	$40,688	$34,910	$310,931	$136,210	$353,366
1%	$38,978	$468	$105	$2,818	$3,790	$30,318	$18,379	$79,999
0% Minimum	$5	$303	$58	$5	$56	$4,021	$421	$3,242

* Dollar values are percentiles and may not equal the sum of the component parts.

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